February, 1954

Canadian Hospital

- *symposium on trusteeship*
- *addition to McKellar General*
- *on fund accounting in hospitals*
- *an extension course graduate reports*
- *gluten-free diet in the malabsorption syndrome*

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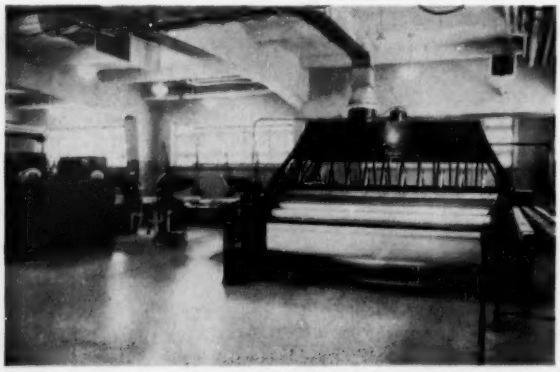

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Contents

Vol. 31 **February, 1954** No. 2

Notes About People 12

Obiter Dicta 31

A Symposium—Trusteeship 33
Col. Leo MacDonald, C. Rufus Rorem, Ph.D., A. L. Swanson, M.D., and D. B. Strudley

A Graduate Reports on C.H.A. Extension Course 39
Sister Mary Angelus

Serving the Lakehead (McKellar General) 40
B. Kaminker, R. V. Johnstone

Fund Accounting 47
Walter W. B. Dick, B.Comm., C.A.

Statistically Speaking, 1952 (Traduction) .. 50
B. R. Blishen, M.A.

Gluten-free diet in the Malabsorption Syndrome 54
K. J. R. Wightman, M.D., F.R.C.P. (C.)

Provincial Notes 58

National Conference on Catholic Nursing Education 60
Sister Denise Lebevre

With the Auxiliaries 62

Book Reviews 66

Bed Assignment Control Board 70
Robert R. Langée, S.B., P.E.

Coming Conventions 94

(For Subscription Rates, see page 96)

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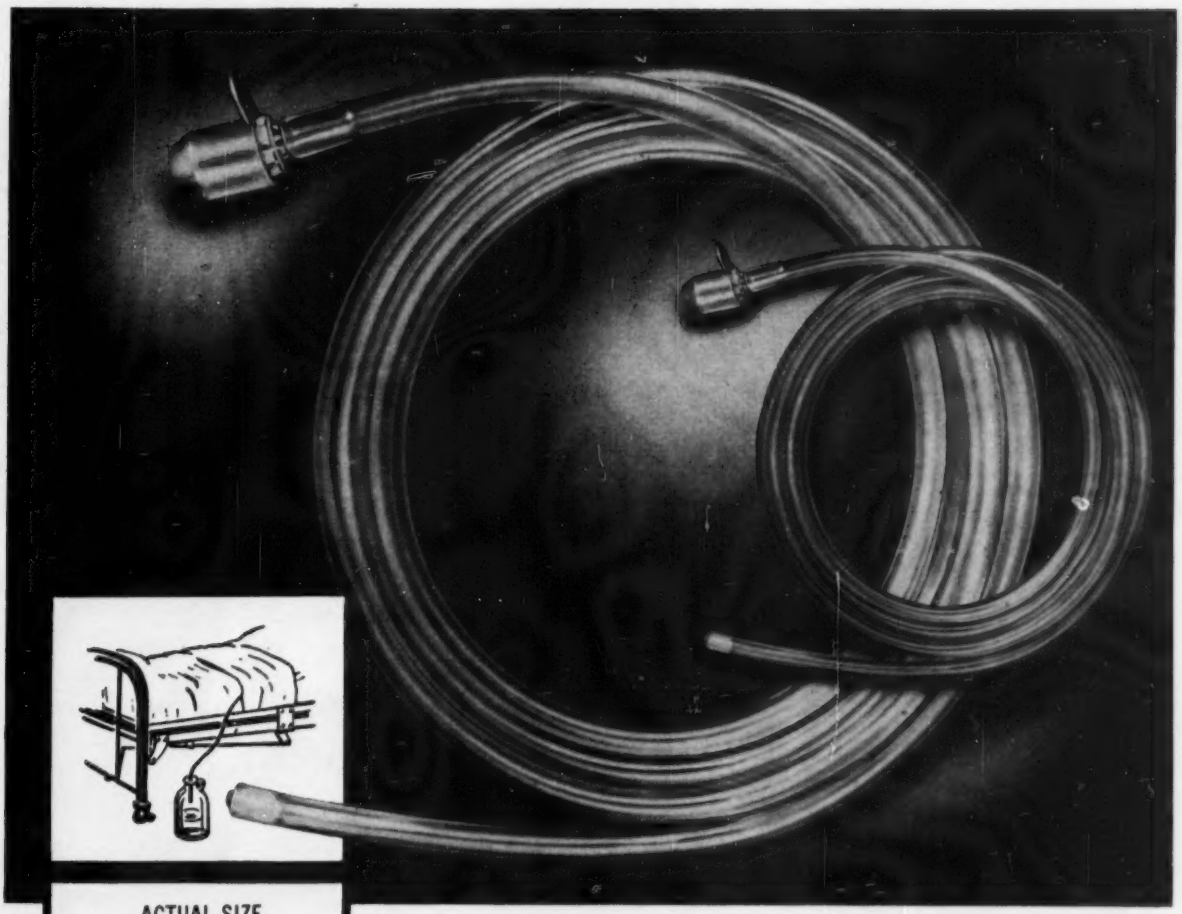

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1000R—3/16" lumen

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Notes About People

Director of Nursing at St. Paul's Hospital, Vancouver

Sister Denise Marguerite, who became director of nursing at St. Paul's Hospital, Vancouver, B.C., last summer, is a native of Penetanguishene, Ont. Following graduation from the general hospital there, she was engaged in various fields of nursing before becoming a general staff nurse at Providence Hospital, High Prairie, Alta. In 1939, she went to St. Paul's Hospital as a supervisor. For six years, she was director of nursing at St. Eugene's Hospital, Cranbrook, B.C. Sister Denise Marguerite holds a B.Sc. degree in nursing education from Seattle University and a master of science degree from the Catholic University of America. Currently, she is secretary of the Vancouver Chapter of the Registered Nurses' Association of British Columbia. Sister Denise Marguerite succeeded Sister Columkille as director of nursing at St. Paul's Hospital.

* * * *

Solomon Grand

Solomon Grand, assistant executive director of Mount Sinai Hospital, Toronto, Ont., died at his home in Toronto, at the age of 32. Mr. Grand was born in Maple, Sask., and received his education in Manitoba and Alberta. He was a graduate of the University of Manitoba School of Social Work. Prior to coming to Toronto, he was assistant to the director of the Jewish Welfare Fund and later was executive director, Central Division of the Canadian Jewish Congress. He joined the staff of Mount Sinai Hospital as assistant executive director in 1948.

* * * *

Dr. Otto Binswanger to Serve as President ad interim of I.H.F.

Dr. Otto Binswanger, president of the Swiss Hospital Association and director of Sanatorium Bellevue, Kreuzlingen, Switzerland, has consented to serve as president *ad interim* of the International Hospital Federation until the general assembly meets on the occasion of the next International Hospital Congress, to be held in Lucerne in May, 1955. Following upon the death of Dr. René Sand, it was the unanimous wish of the Council of Management that Dr. Binswanger should fill this position.

Dr. Binswanger has served the I.H.F. for many years. When the Federation was founded in Switzerland in 1947, as successor to the pre-war International Hospital Association, he became secretary *ad interim* and assisted the president, Dr. Sand, in the conduct of the Federation's affairs until 1948, when Captain J. E. Stone of London, Eng., was invited to take the post of honourary secretary and treasurer. From then on, Dr. Binswanger served as an active and most valuable member of the executive committee and, at the general assembly, held in Groningen, Holland, June, 1949, he was elected vice-president.

* * * *

New O.H.A. Appointment

G. Frederick Surphlis has been appointed assistant comptroller of the Ontario Hospital Association. Mr. Surphlis has been with the association since September, 1942, and was employed previously with the Ontario Department of Health in an accounting capacity. His career was interrupted by Army service but he resumed his employment with the Association in September, 1945. An internal audit department was established in 1948 and has been operating under Mr. Surphlis' supervision since that time.

G. Frederick Surphlis

* * * *

Bertha L. Pullen, Reg. N., Resigns from Winnipeg General Hospital

Bertha L. Pullen, Reg.N., has resigned from the post of superintendent of nurses of the Winnipeg General Hospital and returned to her native Michigan. Miss Pullen is a graduate of the University Hospital of Chicago, Chicago, Ill. She received her Bachelor of Science degree and Master of Arts degree from Teachers College, Columbia University. Before going to Winnipeg, Miss Pullen had been director of nursing in the Anna Nerry School of Nursing in Rio de Janiero, at Methodist Hospital, Indianapolis, and had been associate dean of the school of nursing at Baylor University, Dallas, Texas.

* * * *

Charles H. Hair

Dr. Charles H. Hair died in December at his home in Toronto, Ont., after a brief illness. Well-known in medical circles, Dr. Hair had practised as a surgeon on the staff of the Toronto General Hospital and also taught at the University of Toronto. For 16 years, he was medical officer of mines with the Accident Prevention Association. In 1937, he was elected president of the Academy of Medicine in Toronto.

* * * *

Elias Clouse

Dr. Elias Clouse of Toronto, Ont., probably the city's oldest practising physician at the time of his retirement two years ago, died on January 11th at the age of 98. Born at Pleasant Hill, Norfolk County, Dr. Clouse attended Simcoe High School, Woodstock College, and Trinity College. He received his medical license from the Faculty of Physicians and Surgeons of

(Concluded on page 16)

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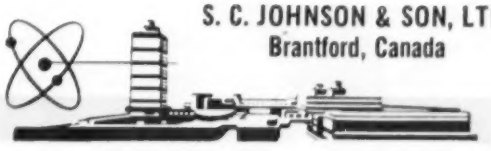

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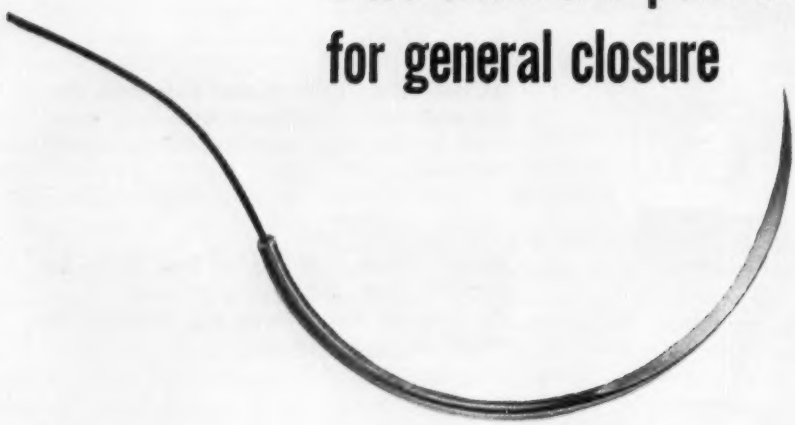

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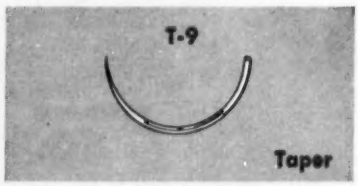

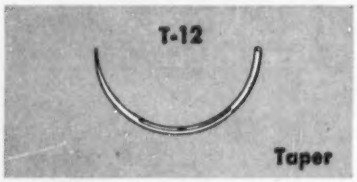

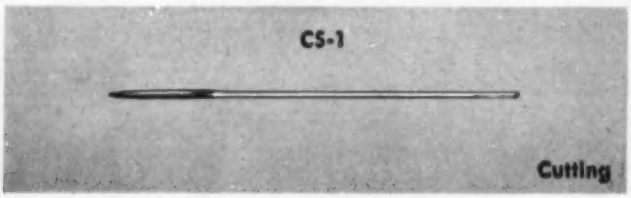

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1548	C, Med. Chromic	27"	T-12	000 to 2
1561	C, Med. Chromic	27"	T-18	000 to 1
1563	C, Med. Chromic	27"	T-19	00 to 1
1547	C, Med. Chromic	27"	C-9	000 to 2
687	C, Med. Chromic	27"	C-10	000 to 2
689	D, Extra Chromic	27"	C-10	00
685	D, Extra Chromic	27"	C-12	0 to 2
693	C, Med. Chromic	27"	R-1	00 to 1
691	D, Extra Chromic	27"	R-1	00, 0

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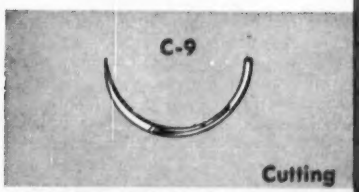
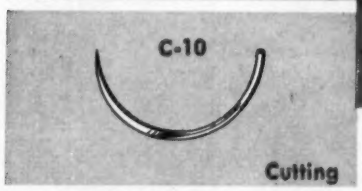
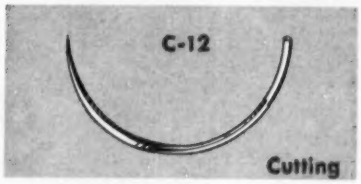
1378	Black Braided Silk	30"	C-9	000 to 1
1379	Black Braided Silk	30"	T-9	000 to 1
1380	Black Braided Silk	30"	CS-1	000, 00, 0
1397	Black Braided Silk	30"	T-12	000 to 2







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Notes About People

(Concluded from page 12)

the University of Glasgow and also the Royal College of Physicians and Surgeons in Edinburgh. He took further postgraduate work in London, England, and Johns Hopkins Hospital, Baltimore, Md., where he studied under the late Sir William Osler. On returning to Toronto, Dr. Clouse interned at the Toronto General Hospital and subsequently established a practice in that city. He was one of the founders of the Toronto Western Hospital and, for some years, was known as the dean of the staff. He had also served on the board of that hospital.

* * * *

Honour Long-time Employees of Toronto Western Hospital

The Board of Governors of the Toronto Western Hospital, Toronto, Ont., recently gave a special recognition to staff members who had served the hospital for a quarter of a century or more. At an inaugural dinner meeting of the Twenty-Five Year Club, held last December, 26 employees were presented with gold watches in appreciation of their continued and devoted service.

Paying tribute to the hospital staff and superintendent, A. J. Swanson, Dr. Sigmund Samuel, president of the board, said: "This hospital is operated like a large, well-directed family. It has its ups-and-downs but has come through marvelously. The excellent leadership has come from a man who is a kindly father to this great organization".

Hospital employees honoured by the board were: Marjorie Agnew, Arthur W. Bailey, Alfred Betts, W. J. Cryderman, David B. Grainger, Ida Gray, Eva Hamilton, Constance Johnson, Gwladwen Jones, Annie Lawson, W. S. Madill, Alberta Mandley, Arthur S. McComb, Laura McDougall, Hilda Mitchell, Ernest Pitman, Gladys J. Sharpe, Dora Shrimpton, Eveleen Sloan, Lenna Smith, Lillian Sparrow, Arthur J. Swanson, Mary Thomas, James Trangmar, Edith Wark, and J. Stuart Wilson.

• Earle C. Westwood has been appointed to the board of management of Nanaimo Hospital, Nanaimo, B.C., by the provincial cabinet. Mr. Westwood will serve for two years and succeeds S. V. W. Isaacson who resigned recently.

• Sister L. Noel has left Holy Cross Hospital, Calgary, Alberta, where she was superior for the past three years. She is now in Montreal.

• Eleanor Graham has resigned as director of nursing at the Royal Columbian Hospital, New Westminster, B.C., to join WHO in India.

• During his recent seven-week tour of hospitals and medical schools in Australia, Dr. Malcolm T. MacEachern, Chicago, Ill., was presented with an honorary fellowship in the Australian Institute of Hospital Administrators and made honorary consultant in hospital administration to the Royal Prince Alfred Hospital.

• J. Ronald Chapman was elected chairman of the board of trustees of the Victoria Hospital, London, Ont., last December. He succeeds T. F. Kingsmill.

• John Strong has been appointed secretary of the board of directors of Wingham General Hospital, Wingham, Ont. He succeeds Mrs. Elmer Walker.

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Extension Courses

Those interested in applying for either the extension course in hospital organization and management or the extension course for training medical record librarians, commencing in September, 1954, should submit their applications to arrive not later than March 31st. The demand for both courses has been heavy and already a considerable number of applications are on file. Therefore, no assurance can be given that applications received after March 31st will be considered for the 1954 enrolment.

● The extension course in hospital organization and management is now in its third year of operation and, to date, approximately 150 students have been enrolled. This is a two-year program, during which lessons are prepared through home study for eight months each year, followed by a four-week intramural period in a Canadian university. A certificate is granted upon graduation.

● The extension course for training medical record librarians commenced in September, 1953, and has a present student body of 40. This is also a two-year program, similar in operation to the other extension course, although a student may elect to take the first year only. The intramural periods, in each case, are spent in Canadian hospitals which have been approved for the purpose. A certificate is granted upon completion of each year of the course.

Information and application forms may be obtained by writing to: The Secretary, Committee on Education, Canadian Hospital Association, 280 Bloor Street West, Toronto 5, Ontario.

All Research Co-ordinated at Hospital for Sick Children, Toronto

The Hospital for Sick Children, Toronto, has announced a major reorganization of its research program with a view to immediate expansion. Replacing a system in which individual research projects were carried out largely on the initiative of the departments doing them, the hospital is setting up a new Research Institute under the direction of Dr. Andrew J. Rhodes. The Institute will be responsible for integrating all the hospital's research, for applying for funds, and co-ordinating the work of different departments to obtain best results.

The director of the institute, Dr. Andrew J. Rhodes was born in Scotland and is a graduate of the University of Edinburgh. He became professor of virus infections at the University of Toronto in 1947 and was a research associate at Connaught Medical Research Laboratories, Toronto, from 1947 until 1953. He has been co-author with Dr. C. E. van Rooyen, Toronto, of two books on virus diseases and is best known for his research in poliomyelitis. He is a member of WHO's committees on poliomyelitis and virus diseases.

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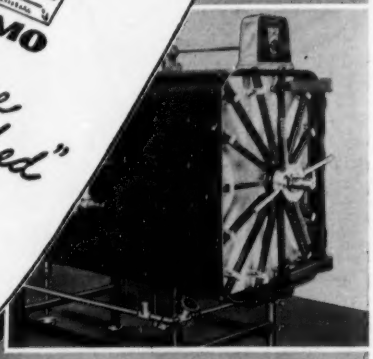
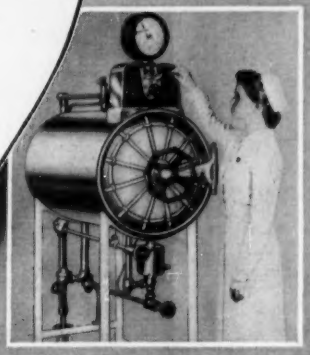
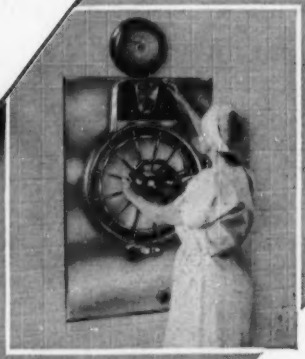


APRIL
MEMO
Announce "All-Welded" Monel Construction for American Sterilizers
1949



MEMO
Announce "Cyclomatic-Control" for American Sterilizers
1950



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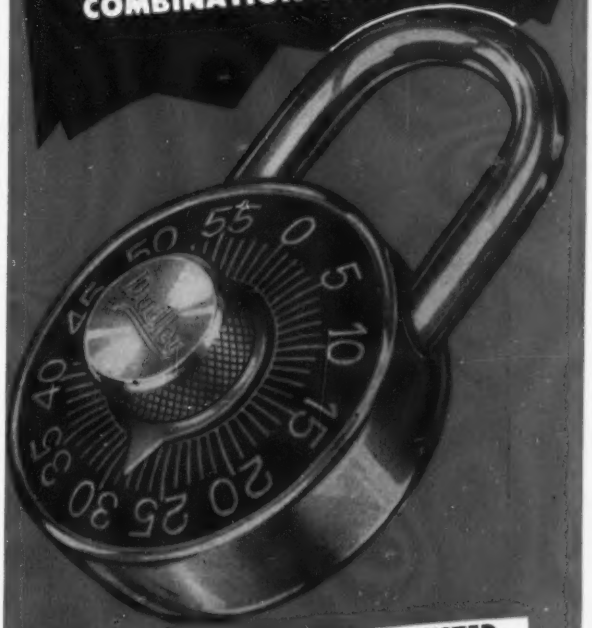

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*U.S. Patent No. 2,441,498

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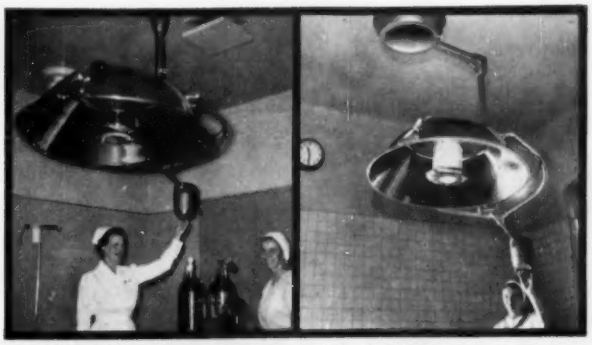

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NEW YORK CITY—"The Surg-o-beam is especially easy to maneuver and adjust," says Mrs. E. Davis, Circulating Nurse of Manhattan General Hospital.

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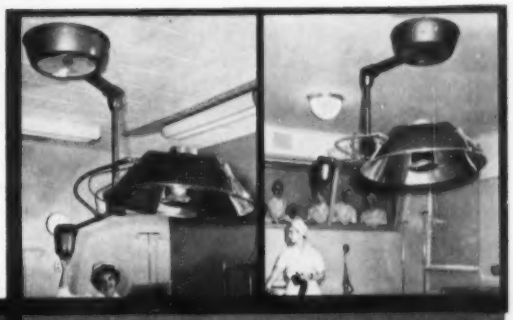

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MONTREAL, CANADA—Student nurses Denise Le Francois and Jacqueline Hebert inspect Ohio Chemical equipment in one of the 16 operating rooms at Hotel Dieu.

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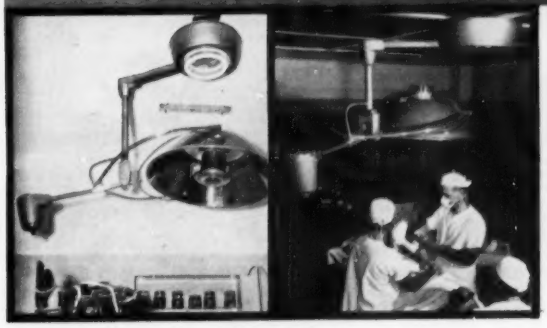
ST. LOUIS, MISSOURI—A recent installation of Ohio's new Surg-o-beam operating light in the operating suite at St. Anthony Hospital.



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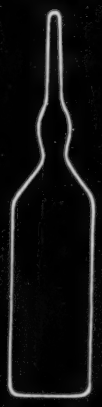

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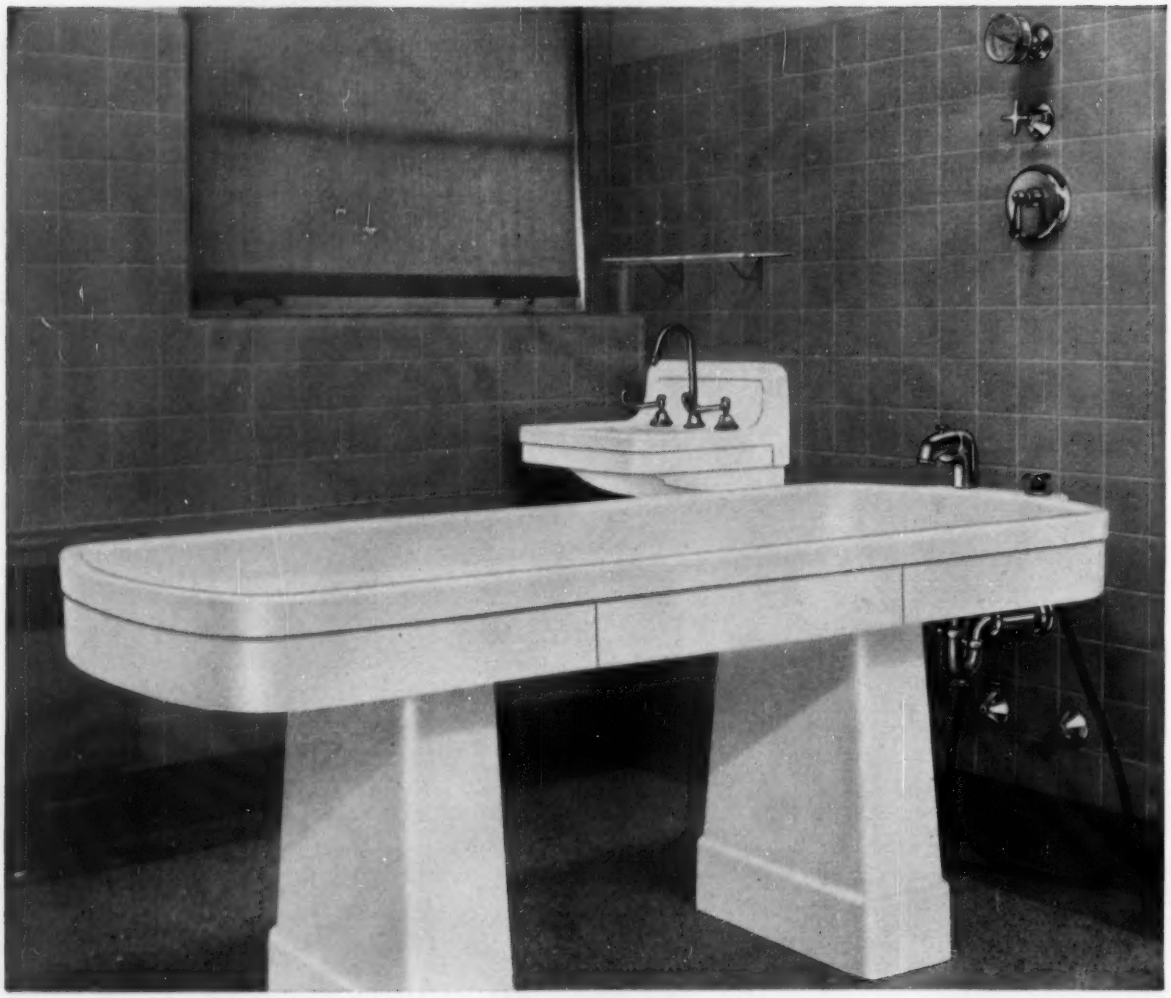

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IN BACKGROUND: Crane Norwich Lavatory, of vitreous china.

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The Canadian Hospital

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Obiter Dicta

For the Attention of Trustees

FOR SOME time *The Canadian Hospital* has followed the policy of directing certain issues toward specific groups in the hospital field. These special issues, which appear every three to four months, are not devoted exclusively to one topic but are designed to delve more deeply into a given subject than is usually possible. Their purpose is to encourage the interest of all readers in some particular aspect of the hospital field.

This month we approach one of the key groups in the hospital family with a symposium on trusteeship. It is hoped that these articles will be read widely by trustees because, despite the tremendous responsibility which rests upon them, these "upper echelon" people all too often have an inadequate grasp of hospital affairs in general.

By and large the board of trustees or board of governors is responsible for everything that goes on within the institution; although, by delegation of authority, the actual administration and medical care are carried out by others. Nonetheless, if incompetent physicians are appointed, if ward nurses are negligent, if patients' records are improperly released, if faulty construction produces a hazard which results in injury, the hospital, through its board of trustees, is liable. While delegation of authority is essential, it does not remove responsibility. Therefore, it is necessary that each and every trustee have a clear basic understanding of how the hospital operates. He need not know the details of administration, nursing, or the many other phases of hospital operation, but he must understand the over-all organization and the part played by each department in providing care for the sick, safely and efficiently.

We know of several areas in Canada where trustees have formed active regional or local groups for the purpose of education and information. This interest is highly desirable and we would appeal for the extension of the movement. Most trustees, realizing that they assume a serious responsibility as well as an honour through their appointment, are looking for a means of keeping themselves informed. While the majority of articles in hospital journals are directly or indirectly of value to them, we hope that this issue of *The Canadian Hospital* will stimulate more trustees to contemplate carefully the part they play in hospital affairs. We hope also that more of them will be encouraged to write about their experiences and observations for the benefit of others.

The Common Denominator

ON JANUARY 12th, officials of the Ontario Blue Cross Plan for Hospital Care announced an extensive revision in rates which represented an average increase of approximately 26 per cent. Since the plan was faced with increasing hospital costs and utilization which would result in deficits if previous rates were continued, drastic action was necessary. The reaction of the press, of labour, and of other groups was immediate and likewise drastic. Demands for a national insurance scheme, accusations against the Blue Cross administration, and pointed questions on hospital costs were typical of public response. Although the Ontario Hospital Association and its Blue Cross Plan are following up with an intensive publicity campaign and have valid answers for all criticism, the Ontario public has had a severe shock.

Similar situations have been, and will be, occurring in other provinces, including those with government-sponsored plans. In each case, whether it be an increase in a voluntary or in a government hospital plan, the common denominator is hospital costs. There may be charges of poor administration, of the need for a socialized plan, and so on, yet inevitably the question is asked, "Why is hospital care so expensive?"

All of us in hospital work know the answers and have attempted to interpret hospital charges to the public. Yet, despite intensive public education, the man in the street has a short memory for the factors, beyond our control, which have led to higher costs; and he has a very clear awareness of how much his pocketbook is affected. As purveyors of hospital service, we find ourselves in the anomalous position of having developed a product so excellent that we must constantly explain its cost to the purchaser.

A socialized plan for hospital care, mooted by some as

a panacea to our financial woes, would not be a cure-all. Indeed, the increased utilization that would inevitably result, to at least some degree, would create still more cost that *must be paid*. No matter what type of hospital plan and however efficiently it may be administered, the basic problem that still remains is the cost of *good* hospital care. If the public want the latest drugs, the most modern equipment, highly skilled staff—in a word, the best possible care when they are sick or injured—they must understand the cost and be prepared to pay in one way or another.

Oddly enough there seems to be much less worry about costs in other fields. Most people desire to have good food, shelter, clothing, and extras such as automobiles and television sets. What is more, they do not question the high price of excellent cloth because they expect to pay for quality. Many merchants have had the experience of offering a quality product at a reduced price only to have the customer become suspicious of its value. There is no doubt that most citizens want the best available care, even extras, for themselves and their loved ones when illness strikes. Witness the tendency to purchase hospital plans offering semi-private accommodation in preference to those supplying ward accommodation—a tendency that has been so strong that many hospitals have been forced to alter public wards to semi-private and private rooms to meet the requirements. Yet, despite public demand for the best possible care, there is a marked reluctance to pay the cost.

Hospital charges are not high considering the return in terms of lowered mortality and greater likelihood of cure. There can be no price set on a life saved, nor even on complete restoration of good health as opposed to a partial cure that might result from inferior hospital care. Hospital costs are not high in relation to other goods and services in these times of inflated dollars. If the public would be satisfied with cheaper standards of care, or if labour would wish to see hospital employees receive lower wages, or if the cost of food, medicines, and other essentials were to come down, hospital charges could be reduced.

There would seem to be one main hope for solution of the problem, *i.e.*, an educational program for the public that is as forceful, as effective, and as *continuous* as the advertising employed by pharmaceutical houses, automobile manufacturers, and others. We are offering a product which the average citizen expects to be of high quality but hopes he will not require. Most manufacturers endeavour to produce a product of high quality which the public is anxious to obtain. While we are not "selling" in the hope that more of our products will be sold, we must, even more than these other salesmen, convince the public of the true value of our services.

Fund Accounting: benefits that accrue from

THROUGH its official publication, *The Canadian Hospital Accounting Manual*, the Canadian Hospital Association advocates the adoption of "Fund Accounting" by Canadian hospitals. Through agreement reached at dominion-provincial conferences on hospital statistics, the departments of health of each of the ten provinces of Canada likewise advocate this system of recording financial transactions and presenting financial statements.

The advantages accruing generally from the institution of uniform accounting practices in hospitals will be recognized by most. However, the benefits arising from, and the reasons for the development of, this particular approach to uniform hospital accounting practices may not be so evident.

Mr. Walter Dick, Chairman of the Canadian Hospital Association's Committee on Accounting and Statistics has set out the essential facts relating to this subject in his article appearing on page 47. We hope that this excellent article will be read by every trustee and certainly by every administrator, as well as by hospital accountants, in order that all may have a broad general understanding of this matter which is receiving so much attention in Canadian hospitals at the present time.—*M.W.R.*

Nous avançons—nous pouvons faire mieux

LA première partie du rapport annuel des hôpitaux pour l'année 1952 a été publié le mois dernier, par le bureau fédéral de la statistique (voir page 50). Ceci marque la réalisation à peu de choses près de la promesse faite par le bureau il y a un an. Nous felicitons le statisticien du Canada et son personnel d'avoir réussi à mettre si tôt ces données précieuses à la disposition des hôpitaux. Certains hôpitaux ont tardé à faire parvenir leur rapports. C'est la seule raison pour laquelle les résultats déjà assez satisfaisants n'ont pas été dépassés.

Ceux des hôpitaux et les autres intéressés désirents ces renseignements le plus tôt possible chaque année. Le bureau, sachant que le rapport peut servie un but utile si on le reçoit assez tôt, envisage le premier septembre comme date à laquelle il essaiera de fournir des données de 1953. Comme toujours le bureau ne peut apporter une telle amélioration de ses services sans l'appui et la coopération sincères des hôpitaux du Canada.

Les formules du rapport pour 1953 ont été révisées et améliorées. Il n'y en a maintenant que deux. La première —renseignements généraux—devra être remplie et transmise avant la fin de janvier, chaque année.

Si, par hasard, tout hôpital n'a pas encore reçu les formules du rapport et un exemplaire du manuel de définitions et instructions relative aux formules, on pourra les obtenir sur demande à son ministère provincial de la santé ou au bureau fédéral de la statistique.

Results are better—can still improve

PART I of the Annual Report of Hospitals for the year 1952 was released last month by the Dominion Bureau of Statistics (see page 50). This falls just short of the objective set a year ago. We congratulate the Dominion Statistician and his staff on the speed with which this valuable data has been made available. Even better results would have been possible if a relatively small number of hospitals had not been tardy in forwarding their returns.

Hospital people and other interested persons want such data as early as possible each year. The Bureau, accordingly, is raising its sights and, this year, has set the month of September as its objective for the release of hospital

(Concluded on page 82)

Who Should Serve?

TRUSTEESHIP

Col. Leo MacDonald,
Charlottetown, P.E.I.

IN GENERAL, hospital trustees and administrators are aware that the hospital is an integral part of the community and that its success will depend on how it meets the needs of the community it serves. The administration of a hospital is much more than mere institutional business management; rather it is medical administration in the broadest sense. Therefore, the whole scope of hospital administration must be patterned on the premise that the hospital is an essential part of the community—filling an essential need—and, in turn, depending on the community for support, inspiration, and actual success. It is a well-known fact that the success or failure of a hospital is not measured solely by the financial statements showing black or red. The rule by which the success of a hospital is measured should be the success or failure it has achieved in meeting its objectives, namely—care of the sick and injured, teaching, research, and community welfare.

The people to whom the general efficiency of our hospital is entrusted are usually known as a board of trustees. Theirs is a sacred trust. In terms of money alone this is a big trust because our modern hospitals are equipped in most cases with intricate scientific equipment and staffed by highly trained technicians, educated to cope with the problems of modern medical science. It is well to remember also that the hospital belongs to the people—to the community.

It is, therefore, of vital importance that the board of trustees should be made up of men and women who have demonstrated their executive ability in their chosen field, men who hold an honoured place in the community and whose integrity and worth are recognized. The time has long passed when appointment to a hospital board is to be considered merely an honour. Men with breadth of vision, with an interest in the health and welfare of the community, with a willingness to give of their time and effort are those who should make up the board of trustees.

Functions

It is recommended by authorities on hospital administration that the board should appoint certain standing committees such as executive, finance, building, and public relations. Other functional committees may be appointed for certain specific tasks. These committees usually disband on completion of the assigned duty. The main functions of the board are:

1. to formulate policy
2. provide competent administration
3. develop and carry out a sound financial program
4. enforce high standards of service
5. co-operate with other health and welfare organizations in the community
6. establish favourable public relations
7. to provide all possible care within the competence and resources of staff and plant.

To carry out the above policies it will be necessary for the board to be clear and concise in its directions, to use the regular and normal channels of communication and see to it that sound principles of organization and administration are followed. This leads us naturally to the question: Should the administrator be a member of the board? In my opinion, he should be and not merely in name only. He or she should be fully accepted as any other appointee to the board with a real voice in its discussions and the same responsibilities as any other member.

It may be thought by some that the administrator with his cognizance of the inner workings of the hospital will tend to "run" the board. The board should have confidence in its administrator and should give him wide executive and administrative responsibilities within the limits of board policy. The advantages are obvious. May I mention two: the board's ability to

From an address presented at the Maritime Hospital Association Convention, St. Andrew's-by-the-Sea, N.B., June, 1953.

make decisions more quickly because the administrator is present to offer his point of view; and closer contact for board members with day-to-day problems of the hospital.

Perhaps here it might be well to ask the question: Is it wise to have a member of the medical staff on the board? Some authorities advise against this practice because of fear that the purely medical part of the hospital will receive undue attention, to the neglect of other departments, or that the physician in question will be placed in a preferred position to his colleagues on the staff. Opinions differ on this question. A great deal depends, of course, on the particular doctor involved. Some boards prefer to appoint a retired or inactive physician.

Esprit de corps

Needless to say a spirit of harmony and co-operation is an essential element in the smooth and efficient functioning of any board. Unless there is a justifiable pride and *esprit de corps*, as well as a continuing urge to give of the best among the members of the trustee body, there will be difficult times ahead for any hospital. In other words, the administrative staff and the medical staff must feel that the leadership of the board is of the highest order and that, in turn, the board has every confidence in the zeal, ability, and trustworthiness of all members within the various departments of the hospital. All must be motivated by the primary principle of considering what is best for the patient.

The Administrator

Now we turn to the key person in the hospital—known as the administrator. Who is he to be? What are his qualifications? What are his duties?

The administrator is the chief executive representing the board. He derives his authority from the board and is responsible to it. His position is equivalent to the managing director of any well run commercial or industrial company.

An administrator must have certain qualifications. First, he must like to work with and have the ability to handle people. He must know his job through training and experience. Also he must be of fine character and have a pleasing personality.

The duties of an administrator are manifold. However, they may be summarized as follows:

Outside the hospital—the administrator "sells" his hospital to the community by taking part in community affairs, speaking to service clubs, delivering radio addresses, et cetera.

Within the hospital—he gives directions, advises the board and suggests policies, and is responsible for setting up a functional organization within the staff, as well as seeing to it that the various parts of the organization run efficiently and smoothly.

To set up and carry through a functional organization within the staff, the administrator should:

(a) prepare an organizational chart showing all divisions, such as accounting, nursing, dietary, laundry, engineering, maintenance, et cetera, and each division should be broken down into its several departments.

(b) list heads of departments with members of the staffs.

(c) summarize duties of each department briefly.

(d) delegate authority—and work through the departmental heads.

(e) do spot checks at infrequent intervals.

(f) organize regular departmental and division meetings—attend some if possible.

(g) call for necessary reports and be prepared to help iron out departmental difficulties.

(h) keep managerial control through accounting and statistics. In this connection it is essential that a budget be prepared in collaboration with department heads who should receive a monthly statement of their revenue and expenditures.

(i) keep control of supplies, marketing, et cetera.

(j) keep the board fully informed.

It is considered essential that the administrator have ample time to study proposed structural changes well in advance of any commitment by the board regarding new construction or renovation to existing buildings. Many of our hospitals were built long before the idea of step-saving became a real is-

(Concluded on page 98)

Challenge and Opportunity

C. Rufus Rorem, Ph.D.,
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TRUSTEES AND administrators of voluntary hospitals have an obligation to achieve the greatest possible use from the resources entrusted to them. The need for "effective use" is applicable both to daily management and the over-all responsibilities of hospital trustees.

The classical distinction between the duties of trustees and administrators is that between policy formation and management. Policy formation relates to continuing problems; management concerns itself with daily solutions. Trusteeship is concerned with the entire hospital and its relation to the community. Administration deals with service within the hospital and the achievement of specific goals established by the trustees.

Many problems of hospital care are the same for trustees as for the administrators. The difference is one of viewpoint. The trustee is concerned *whether and when* something should be done; the administrator with *how and by whom* it should be done.

It is assumed, of course, that each trustee is interested solely in his opportunity to render a public service through applying his special knowledge, skill, judgment, effort (and even his money) to furthering the program of the hospital. This paper dismisses, as unworthy of serious discussion, the idea that a trustee should regard his board membership as furnishing him with a captive customer or serving a public relations function for his professional or business activities. Disapproval is even given to the notion that a trustee has a right to "meddle" in those administrative details in which

An address presented at the trustees' section of the Ontario Hospital Association Convention, Toronto, October, 1953.

he may have a special competence.

A few aspects of service in hospitals are presented here to point out the challenge and opportunity of trusteeship. They are expressed as questions on the theory that it is often more difficult to state a problem clearly than to find a solution. Frequently, a hospital's difficulty in dealing with a situation arises from the fact that both trustees and management have frantically tried to find a solution to a problem which has not been clearly recognized.

The ensuing questions are all related to effective utilization, particularly those arising when the board is contemplating the expansion, renovation or replacement of existing facilities. But they are equally important when a community is deciding whether a new hospital should be established. The establishment or expansion of a hospital is not an unmixed blessing. If it is used ineffectively, there results both a lowering of professional standards and a waste of economic resources. No hospital is a law unto itself. It must be fitted into a total plan of community service, including the efforts of the medical profession and the work of other institutions available to the local community.

Is this hospital necessary?

Is this hospital necessary to the community? The answer depends upon the point of view. Some physicians on the attending staff may argue that a hospital is necessary to their livelihood. A religious body may feel that the institution is a proper outlet for its humanitarian service and ideals.

A community's needs may not always coincide with the ambitions of a hospital's trustees or attending staff or even the philanthropic preference of a large contributor. Some potential contributors may be more interested in total facilities in the community than the continuance and expansion of a particular hospital.

High ultilization of bed facilities at a hospital is not a convincing argument that it should be expanded, particularly if there are empty beds elsewhere in the community. When there is a wide discrepancy between the percentages of bed-occupancy among local hospitals, some people will think or say "why don't the doctors and patients use the other institutions?".

Idle plant and personnel are presumptive evidence that a community's needs have already been served. The presumption may be wrong. But a relucant supporter can hardly be criticized if he feels that a community should not provide more bed facilities until it has found a way to use those already on hand.

Data for measuring effective utilization of a single hospital, or for a total community, are necessary for any institution to relate its program to the community need. Some of the basic facts are: (a) bed capacity of each institution, classified by number of beds per room and special limitations on their use; (b) admissions and patient-days per hospital, classified by accommodations, diagnosis, and seasonable variation; and (c) check list of diagnostic and treatment facilities at each institution, with data as to their percentage of utilization.

Prospects of utilization

What are the immediate and long-run prospects of utilization of a hospital facility? The public needs evidence to justify the prospects and the "prospectus". Some of the types of questions which are properly a concern for hospital trustees include the following: Is the hospital's waiting list (if it has one) the result of inflexible classification of room accommodations? Would a shift in the proportions affect the percentage of occupancy? If the hospital is expanded, will some physicians merely transfer their patients from other institutions?

Bed occupancy data has often been discussed as the most significant measure of hospital utilization. But the dormitory facilities of a modern hospital represent scarcely 25 per cent of its usable floor space. A high per cent of the capital investment is required for special diagnosis and treatment, both for bed-patients and for those who are up and about. More attention should be given to the percentage of utilization of the diagnostic equipment and professional personnel, with records of the number of hours per week when they are kept in use. It is ineffectual for patients to occupy a hospital bed several days until a consulting radiologist arrives to examine films or patients.

Buildings and Equipment

Do the present buildings and equipment contribute to a high quality of service and reasonable financial economy? This question involves engineering as well as medical and administrative judgment. Non-fire resistant facilities may endanger the lives of patients, employees, staff or visitors. Likewise, improper design and lay-out may interfere with effective use of personnel and supplies. But these facts do not justify an irresponsible attitude toward the abandonment of present plant and equipment.

A structure which is unsatisfactory for one purpose may serve reasonably well for another. Nursing pavilions for bed patients have been transformed frequently to employee residences, class rooms, out-patient services or offices for private medical practitioners. In Philadelphia, a large general hospital unsuitable for acutely-ill patients was renovated recently so that it will last another 50 years for custodial service.

Plans of other hospitals

Does the hospital's future program take into account the plans of other hospitals in the area? It is possible that a hospital may serve its community best by supplementing rather than duplicating the program of another institution. The plans of one hospital are of vital concern to the trustees of another institution. Occasionally such facts are learned "the hard way". For example, the trustees of an institution in a growing industrial area recently asked a national concern to contribute toward the cost of bed expansion, inasmuch as the firm had already contributed to the "drive" of another hospital. Officers of the business reached an entirely different conclusion. In their opinion the gift to the first hospital absolved them from contributing to the second, since the need for hospital beds had already been met.

Co-ordination of hospital facilities is a dynamic concept which involves action by administrators, physicians, and trustees, as well as the taxpayers, voluntary contributors, and patients. A hospital is people at work, not merely a composite of brick, stone, structural steel, and clinical facilities. Planning and co-ordination are never accomplished in the abstract.

Some students of public health and medical economics believe that competition among medical staffs makes it impossible to achieve voluntary co-ordination among hospitals. If true, this viewpoint forebodes ill for the private practice of medicine and the future of voluntary hospitals. If com-

(Continued on page 75)

To further

Staff Education

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Toronto.

FOR THE purpose of this paper it is assumed that technical and scientific preparation is, *ipso facto*, education in some form. It is further assumed that the term "hospital executive" includes the administrator, his assistants, and heads of major departments. Persons in charge of the larger departments will have personnel problems, will have to meet difficulties in management and control, and most of the other responsibilities that accrue to an executive.

Primarily the executive is responsible for his own education and cannot expect his board of trustees to provide an easy route to higher learning. However, training should be of value both to the individual and to the employer and, therefore, in many cases both should share in this obligation.

It has been affirmed by many authorities that trustees are responsible for the quality of care offered by the hospital. They are charged, therefore, to take proper steps to ensure that competent medical men, administrators, nurses, technicians, and all other types of professional or skilled staff are engaged and that proper standards of work are maintained. Fortunately, the majority of hospital staff come to the hospital either fully trained or, as in the case of interns and nurses, to complete a definite course of training. To a formal education must be added a good measure of experience, educational refreshment, and periodic analyses of the individual's competence. However, the completion of a definite program of education by the prospective employee gives the trustees a basis for judgment in their selection of a large segment of the hospital staff. Likewise, definite academic attainment gives the nurse, doctor, or technician, a tremendous advantage in taking over a position and in gaining further broad experience. Imagine the waste of time that would result if our technical staff gained all their knowledge through experience on the job, with little or no planned instruction.

Until relatively recently, there were very few training courses available for executive staff. Now that courses have been established, there are, in many instances, large backlogs of applicants. Even for younger personnel who, theoretically, are more easily able to embark on a course of training, there is often difficulty in gaining admission to a school. Also, there may be the problems of expensive tuition fees, the cost of travel, and the lack of income during the training period. These are serious questions to the oncoming group of future executives. Such problems loom much larger to hospital executives who are in need of further training but who are already established in positions. They have the added responsibilities of home, family, and security. Therefore, many executives cannot hope to achieve the necessary education without at least partial financial assistance.

The modern-day hospital contains a heterogeneous group of executives. The new assistant superintendent may have completed a postgraduate course in hospital administration and also have had considerable experience; or he may be a former bank clerk who has never entered a hospital before except perhaps as a patient. The superintendent of nurses may have had postgraduate courses in supervision, in teaching, and in operating-room technique, but no executive experience; or she may have had long experience without one iota of specialized training. These variations will be found in almost every department of every hospital, and there will be need for:

1. Special formal education for some executives.
2. Supervised on-the-job training and experience for many.
3. Periodic refresher courses for most executive staff; and
4. Constant study, attendance at meetings, and membership in professional and technical groups for all.

What then is the responsibility of the hospital, and therefore of the trustee?

The individual staff member or executive should be expected to devote extra time, to spend some money, and perhaps to make other sacrifices in order to improve his own position. In the future, as all types of formal executive training become readily available, more and more executive staff will come to our hospitals with advanced technical and scientific schooling. They will thus have assumed a still greater portion of the training responsibility. However, in the meantime, the trustees must take steps to provide, or to assist in providing, education at all four levels (formal education, supervised experience, refresher courses, and study and membership).

Why must trustees do this? Their name implies the reason—they hold positions of trust and are expected by their community to ensure the provision of the best possible care. Speaking of the obligation of trustees, the late John M. Storm, Editor of *Hospitals* and *Trustee*, stated that "They are morally obliged to see that the hospital's quality of both hospital and medical care is as high as the community can provide and support." Of what use is it to state that a proper system of medical records must be maintained if the head of the department has had no training or is not permitted to attend meetings of her association in order to keep up-to-date? How can your superintendent of nurses adequately carry out her responsibilities if she has no konwledge of personnel practices, modern training methods, administrative controls, job analyses, and the like? Can you expect an administrator to be in a position to recommend sound policies of which he has never heard nor had an opportunity to study? Will you permit your executive heads to be placed in the position of being less well informed than younger, more recent staff members? If the trustee is to live up to his name and his calling, he must help to furnish the training requirements that will enable his executives, from the administrator down, to carry out the policies and maintain the standards that will bring about good hosp-

From an address presented at the annual meeting of the Comité des Hôpitaux du Québec, held in Montreal, June, 1953.

ital care. Edmund Fitzgerald, president, board of trustees, Columbia Hospital, Milwaukee, Wisc., in a address to the A.H.A. stated that "an educational program involving the training of doctors, nurses, and lay workers, is obligatory".

What can the Trustee do?

1. With the assistance of his administrator and other executives, he should lay down broad educational policies from which a detailed educational blueprint will be established.

2. Certain key executive personnel will require basic or additional formal training at universities or special schools. For these persons, plans must be made well in advance. Not more than one or two should be away at any time, lest disruption of hospital service result. Sufficient time is needed, also, to negotiate financial assistance in the form of professional training grants and to permit the employee to prepare himself.

3. A detailed plan of in-service education for executives should be established and the plan should be extended to cover other personnel. In-service education should offer special supervision and experience and provide periodic assessment of the executive's progress for the benefit of both his superiors and the individual himself.

4. Refresher courses offered by the various hospital associations by professional organizations in the form of institutes, correspondence courses, and the like, should be made available.

5. Executive staff not only should be permitted but should be encouraged to attend meetings and conventions and to hold membership in their professional groups.

How?

How may this be done? The trustees may establish certain policies that will encourage and indeed practically demand the interest and participation of any worthwhile executive:

(a) by promotion from within the organization wherever possible.

(b) properly graduating salaries commensurate with responsibility, efficiency, knowledge, and service, based on adequate job evaluation or rating (*e.g.*, a good executive nurse should earn considerably more than a ward maid. In some of our hospitals there is such a small salary differentiation that it is scarcely worthwhile for a good employee to assume added responsibilities of an executive post.)

(c) by utilizing professional training grants offered by the National Health Program, in co-operation with the provincial departments of health.

(d) by providing financial assistance for the various forms of training and educational activities.

(e) by encouraging the establishment of training programs within the hospital whenever the size and facilities of the organization permit. (There is no better way to keep executives on their toes than by making them responsible for the training of others.) To quote Judge J. Milton George, "Trustees may have a tendency to criticize their own staff for inefficiency, particularly personnel in key positions. But the fault may be with the board itself. Key people must . . .

(Concluded on page 98)

How to Raise Money

D. B. Strudley,
Vice-chairman,
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Stratford General Hospital,
Stratford, Ont.

EVERY hospital periodically has problems of expansion, renovation, or operating deficits, which present a need to raise money. There are three basic sources of money for hospitals, each of which must be used well and integrated with the others, if the best results are to be obtained. These sources are:

1. Payments for services by hospital patients or by prepaid plans for them.

2. Grants for operating costs, or capital costs, by municipal, provincial, and federal governments, which we all pay in our taxes.

3. Charitable gifts by individuals, corporations, or trusts.

It is unwise to generalize too far, since each hospital, must meet its own problems in its own way; but we have found in our experience that money from these three sources is best used in the following ways.

We believe that the actual operating costs of a hospital, including charges for depreciation, should be met by the operating income from patients, from prepaid plans, and from regular maintenance grants by the province or municipality. If a need for money arises because this has not been done, a review should be made of the operating results—with a detailed examination of all items of income and expense, and keeping questions such as the following in mind. Can any expense be reduced? Can any unnecessary services be discontinued? Are the charges for any of the services too low in proportion to their costs? What is an accepted scale of charges in other similar hospitals? Are the municipalities concerned paying the real cost for their indigent patients? Out of this analysis, realistic budgets of income and expense can be drawn up and put into effect. When this has been done and the hospital can show a balanced operating position, the problem of paying off an accumulated deficit in a planned way will not appear too difficult; and the regular payments required to retire the deficit will of course have been included in the new budget.

One of the most common causes of operating deficits is that the hospital is unable to collect from the municipality the real cost of caring for indigent patients and this is also one of the most difficult problems to correct. If, however, municipal councils will not face up to their responsibility, it is unsound for the hospital to continue to carry on at a loss and then try to lay the blame on the municipality. It would be better to decide to get the needed income from other sources—even from higher rates if no other alternative seems feasible. If this is necessary, be sure that the patients and the public know

From an address presented at the trustees' section of the Ontario Hospital Association Convention, October, 1953.

why the rate increase has been required. Very often that in itself will start pressures that will change a municipal council's attitude.

In any case, however, if money is needed to clean up a series of operating deficits—cure the disease first—then worry about the accumulated debt. You start with two strikes on you, if you try to raise money to pay off the debt before you have shown you can stop further deficits occuring.

Capital Expenditure

The larger and more general problem, when money is required, is that of financing new capital facilities—usually required because of expanding needs. We feel, definitely, that operating costs should be paid by patients but that it is unfair and socially unwise to expect patients to pay in their hospital rates any significant part of the cost of providing new capital facilities. To the extent that these cannot be financed by charitable gifts, they should be financed by grants from the several levels of government—federal, provincial, and municipal. They then are charged through taxes against the whole population that may use the services provided; rather than being paid for by the few people in any year who are unlucky enough to be sick and who are already paying their own hospital operating costs and doctors' bills.

In this day of high income taxes and succession duties, the proportion of capital expenditures that can be covered by charitable gifts is limited. In our own thinking, a realistic target is that we should try to obtain in this way, the amount needed for furnishing and equipping the new buildings but, that the buildings themselves should be paid for by tax funds—made available through grants.

Estimating Costs

When an expansion program seems indicated the first questions that arise seem to be "How do we determine what facilities we need, and what will they cost?" The Ontario Department of Health officials have had experience with the problems of many municipalities; some of which may be quite similar to your own. They can be, and want to be, very helpful; and should be called in at an early stage of the discussions. Having made very tentative decisions as to the amount and kind of accommodation needed, a firm of hospital consultants can be useful in crystallizing the project further, and they, together with architects, can make first estimates of costs. They can also help to produce a first capital budget indicating probable expenditures and income from federal and provincial grants.

This capital budget will, of course, include estimates of construction costs, architects' and consultants' fees, supervision costs, and land costs if these are included. These items are all rather self-evident and are not likely to be overlooked. However, a good many items of expenditure that belong in this capital budget are often missed at this stage and cause headaches later.

For instance, if a vote of the ratepayers is contemplated you will need to provide money for proper publicity to ensure that the by-law is passed; and, perhaps, even to pay the municipailty's cost of preparing and passing the by-law and issuing the debentures. And if the debentures, when issued, are to be sold below par there will be an item of "debenture discount" to consider. Money for publicity is also needed in the case of a public appeal for contributions. The project will probably be financed during construction by bank loans; and interest and insurance for this period can be a sizeable amount. Power and heat supplied to the contractor should also be considered. Building contracts almost never include such items as landscaping, sidewalks, paving, parking areas, sewers, et cetera, and estimates for these should also be included. If the program is for the purpose of expanding the capacity of the hospital, which it usually is, the larger volume of business will involve a larger working capital for accounts receivable and inventory. It is both proper and wise to include this item in the capital budget.

And no matter how carefully you consider it, you cannot hope to think of all the things that you, the architects, and the contractors, will be able to spend money on; and so there should be a substantial item designated "allowance for contingencies". This might vary from 5 per cent of the estimated building costs, in the case of new construction, up to as much as 10 per cent in the case of rebuilding old buildings where it is difficult to know what you are up against until you actually start in to work.

And a word of warning here—tell your consultants or architects to be generous in their estimates of costs and not to try to whittle them down at this stage. The time for that will come later when you are into the details of planning and can make decisions concerning materials or specifications which will reduce costs substantially if that seems necessary and wise. The figures you get at the earlier stage are going to determine your estimates of what money you must raise locally—from your local municipalities and from donations. After setting and publicizing a figure, it can be readily reduced but to revise it upwards is very difficult. Many hospitals know from sad experience the problems which can result from setting the target too low and then having to go back for a second municipal grant, and sometimes even a third one, to bail themselves out.

Fund Raising

Members of the governing board, chiefly local business and professional men, will be the best judges of what you can hope to raise in donations; and making a decision on this is probably the next step. There are fund-raising organizations in this field and, if you contemplate using them, they should probably be consulted at this time so that they will be in agreement with you on a realistic target amount.

The balance then, not covered by federal or provincial grants, or by expected contributions, is what you must expect to have financed by your municipal governments. And another word of warning here—hospitals are usually used by patients from a group of municipalities, typically a town or city and a number of surrounding townships. Too often in the past the town or city has been expected to pay the whole share of the capital cost, although perhaps only 50 per cent of the patients are residents of that municipality. In recent years a number of hospitals, unable to reach agreement with the several municipalities concerned to share the capital costs equitably, have worked out arrangements to ensure that those costs were in fact shared. This point should be considered carefully in connection with any project of substantial size.

A Practical Solution

Our own recent problem, and our solution of it, is typical, I think. We needed $1,000,000 worth of debentures

(Concluded on page 82)

A Graduate Reports . . .

Sister Mary Angelus,
Superior,
St. Joseph's Hospital,
Victoria, B.C.

IT WAS my privilege to have been selected as one of the pioneer students of the extension course in Hospital Organization and Management, which is sponsored by the Canadian Hospital Association. Along with the other 32 members of the first graduating class, I know how much I have profited from the winter study, through numerous contacts made during the summer sessions, the well-planned field trips, and the excellent lectures given by outstanding men in the hospital field. Many questions have been asked me regarding this course and I would like to answer a few in the hope that it may encourage more of our Sisters, already in the field, to profit through this opportunity.

Before speaking of the course itself, I wish to point out a rather strange situation for which it is providing a remedy. For years we have accepted the fact that a Sister must be well prepared according to the best standards before she assumes her duties as nurse, dietitian, laboratory or x-ray technician. Yet the position of administrator has been among the last to be recognized as one for which a definite preparation is needed. While it is not necessary that the administrator become a registered nurse, a qualified dietitian, accountant or executive housekeeper, it is essential that she become familiar with the standards for all these departments so that she can know their needs, what reports to require of them, and how to judge from these reports whether satisfactory results are being attained. If she lacks this measured vision of the true relationship of the parts to the whole, the administrator is very likely to be unaware of conditions detrimental to good patient care, which it is her responsibility to recognize and remedy. Hence great benefits are derived from adequate preparation.

Fundamentals

Due to these and similar considerations it has been recognized in recent years that there should be some form of training in the fundamentals of hospital operation for those who, for one reason or another, were unable to take the formal training offered by universities. To this end the Canadian Hospital Council, in 1950, appointed a Committee on Education to explore the possibilities of such a course. The W. K. Kellogg Foundation gave a generous grant, to extend over a period of five years, to initiate this program. To make the course as complete as possible the facilities and services of the Department of Hospital Administration of the University of Toronto were used to set up the curriculum, to supervise the course and to provide consultations on educational matters. Assistance was also secured from other Universities in both Canada and the United States in the techniques and procedures used in the presentation of lesson material. Thus the course was formulated, three years ago. Each year, before the 31st of March, applications are received by the Canadian Hospital Association (formerly the Canadian Hospital Council). A selection is made from these applications according to the needs of each province and the qualifications of the applicant. The choice is well proportioned throughout the ten provinces with an approximate five or six students from each. The number must be limited to allow for proper correction of assignments and ease in handling classes at the summer sessions.

One of the questions most frequently asked is, "What are the educational requirements?" The answer is that so far no specific list of academic qualifications has been formalized. In fact a considerable variety of backgrounds was encountered among those actually taking the course—several were doctors from the Department of Veterans' Affairs; many were administrators who were former accountants; and in our group there were five nurses who were hospital superintendents. No doubt a good business experience is a great aid in undertaking many of the assignments. In general, however, the best background is a broad and varied one, including sufficient experience and preparation in some phase of hospital work to provide a proper understanding of its language and sympathy for its aims.

Aims of the Course

The purpose of the course is primarily to equip the student with accepted and proven skills which will enable her to work with greater efficiency in the hospital. An additional aim of no less import to the individual is to stimulate her to further research and study in the science and art of management. From the course, the administrator learns how to examine and evaluate her ability as manager of an institution, which is the first step towards greater efficiency. This objective is achieved "through examination of the work of other administrators, the organization of one's own thinking and exposure to direct contact with competent authorities."

During the winter session, the interchange of ideas is through the written lessons. Assignments are due every second week. At the beginning of each lesson the scope and importance of the assignment is explained. We begin by the study of the principles of organization and management and their impact on the hospital of today. In this connection, we may mention that hospital management now ranks sixth among the big businesses of the United States. Next we study the organization of the medical staff and the various key departments, with emphasis on the business office. Each lesson contains extensive reading assignments, some of which are required and are taken from prescribed texts, reprints of articles, and from current journals. There are also supplementary suggested references that may be read either at the time the lesson is being prepared or later on.

I have often been asked what type of assignment is given. For the most part, essay type answers are required, applicable to the hospital in which

(Concluded on page 102)

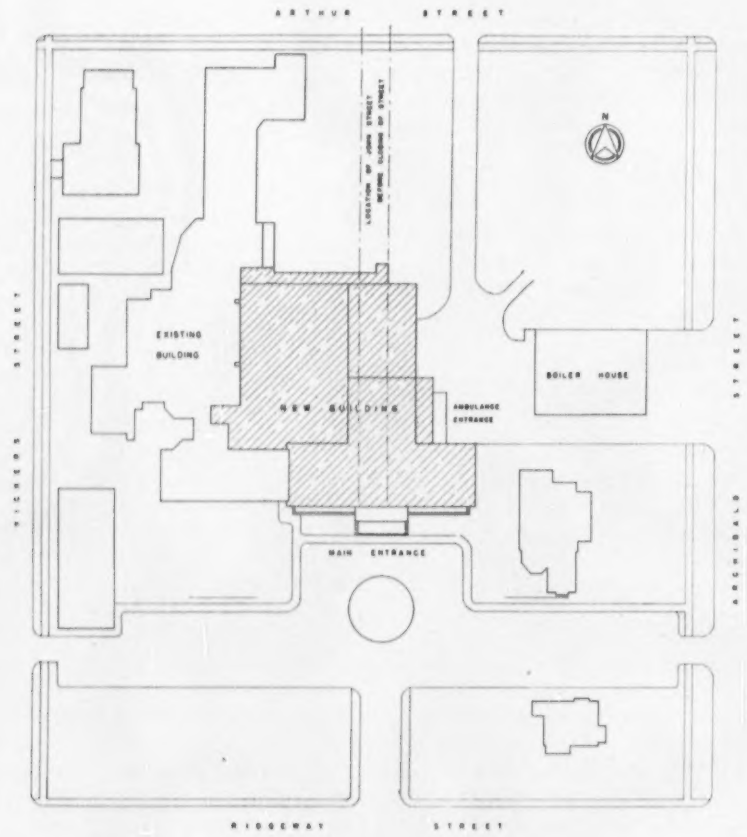
An address presented at the annual convention of the Catholic Hospital Conference of British Columbia, held in Vancouver, October, 1953.

Serving the Lakehead

B. Kaminker,
Toronto, Ont.
R. V. Johnstone*
Fort William, Ont.

LAST SEPTEMBER, the McKellar General Hospital, Fort William, Ont., made a concrete contribution to the health needs of the area, with the opening of a new five-storey wing. During the past few years, the Lakehead has been developing as a medical centre for the vast area known as North Western Ontario and, consequently, the hospitals both in Fort William and Port Arthur have been experiencing an acute bed shortage. It became increasingly evident that the area must become self-reliant since, because of distance, patients with the more complicated types of illness could not be transferred readily to larger centres such as Toronto or Winnipeg for treatment. Thus the McKellar General Hospital and its directors, realizing the need, took on the tremendous task and responsibility of giving the district the type of hospital it required or would require in the foreseeable future.

The expansion program at McKellar General Hospital, therefore, was undertaken with the aim of providing special services which would be of benefit to the district, without duplicating those already in operation in the Port Arthur hospitals. The physiotherapy department was designed to take care of post-poliomyelitis and Workmen's Compensation cases; the provincial laboratory was brought under the hospital roof; and adequate autopsy facilities were established. Because of the lack of hospitals for chronic, convalescent and aged patients in the area, accommodation was provided for these people as well. Care for the mentally ill was also given consideration and psychiatric wards and shock therapy departments were included in the plans for the new wing. Too, the building was designed to service the existing hospital as conveniently and economically as possible. Within the next two years, the older buildings will be renovated in order to provide more beds and services. The over-all plan for the hospital allows for future expansion and a nurses' residence is a major consideration now before the board of directors.

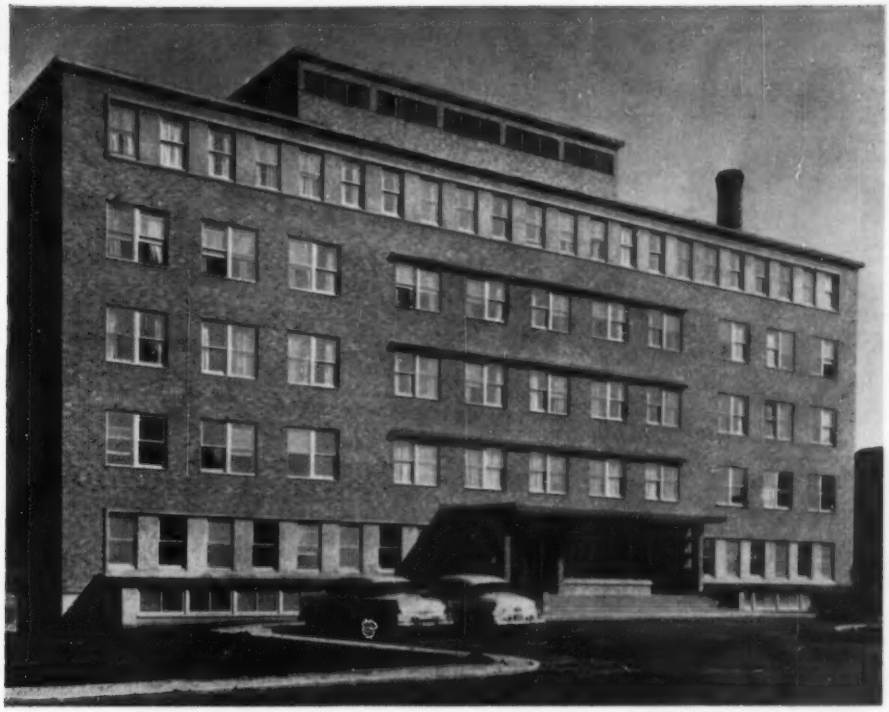


Block Plan of McKellar General Hospital

Construction

As often encountered in the hospital field, the McKellar General represented a difficult problem in planning, since the hospital consists of a group of buildings built at different times on a congested site with no thought given to future expansion. Where the buildings are especially old and obsolete and no additional land is available, the problem simplifies itself. The hospital must move to a new site. However, the problem becomes particularly difficult when the buildings are not yet in poor enough shape to be discarded and land can be made available for expansion. This was the situation at McKellar, further aggravated by the fact that most of the land available for expansion was across the street

**The introduction is written by Mr. Johnstone, administrator of the McKellar General Hospital. The section on construction is by the architect, B. Kaminker of Govan, Ferguson, Lindsay, Kaminker, Langley, Keenleyside, Toronto.*



New five-storey addition to the McKellar General Hospital, Fort William, Ont.

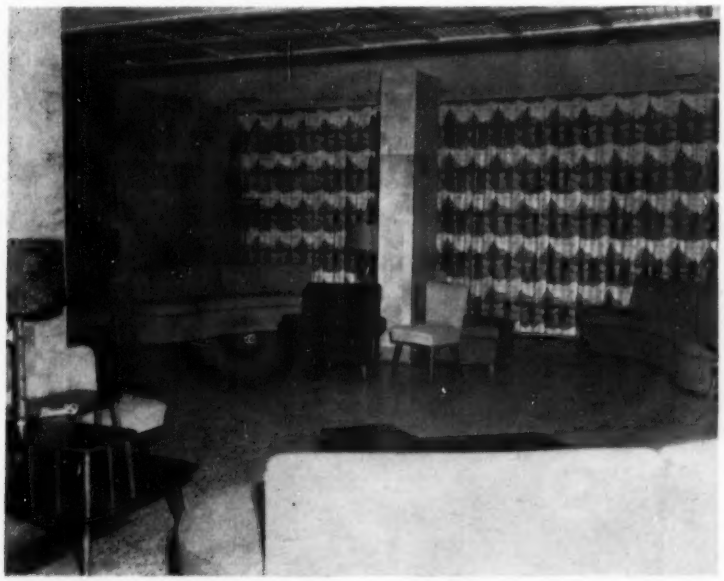
from the existing buildings.

Many months went into the study of various plans until two fundamental principles became abundantly clear to all concerned. First of all, the street separating the two parcels of land owned by the hospital would have to be closed off and become hospital property so that the two areas would be contiguous. Secondly, any scheme predicated on extensive renovations to existing buildings would be economically unsound and would not result in an efficient over-all plan.

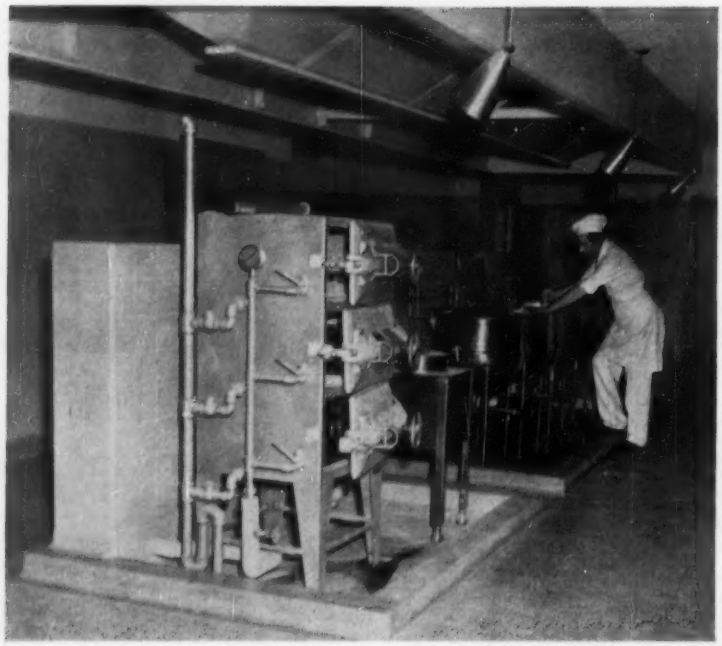
Fortunately, the city authorities were most co-operative in closing off the street (John Street). The practical difficulties of re-routing public sewers, water mains, et cetera, proved not too great and John Street became hospital property.

This opened up an entirely new approach to the planning problem and with the second principle in mind, the architects prepared a new study which in its basic outlines is the scheme which has been followed in the construction. Briefly, this scheme called for, what is in effect, a brand new hospital—a self-integrated unit with accommodation for 167 patients and all auxiliary service departments—to which the old buildings remain attached in a subordinate role. Only the existing south block, which is the latest and most up-to-date of the group of older buildings and the only one of fire-proof construction, was closely integrated with the new construction to which it is immediately adjacent. The other older buildings will be used for goods receiving, general storage, interns' quarters, locker rooms, and some patients.

For the new building, a T-shaped plan was decided upon. This plan has many advantages for hospital design, not the least being ease of future expansion. One wing accommodates

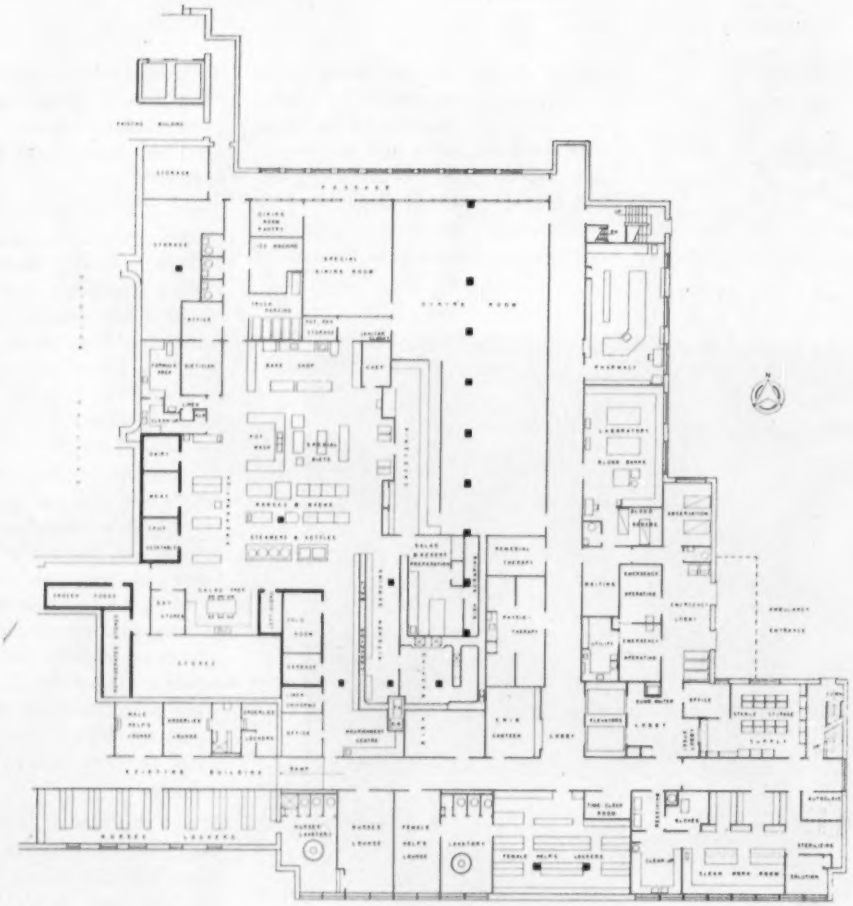


A glimpse of the attractive main lobby.



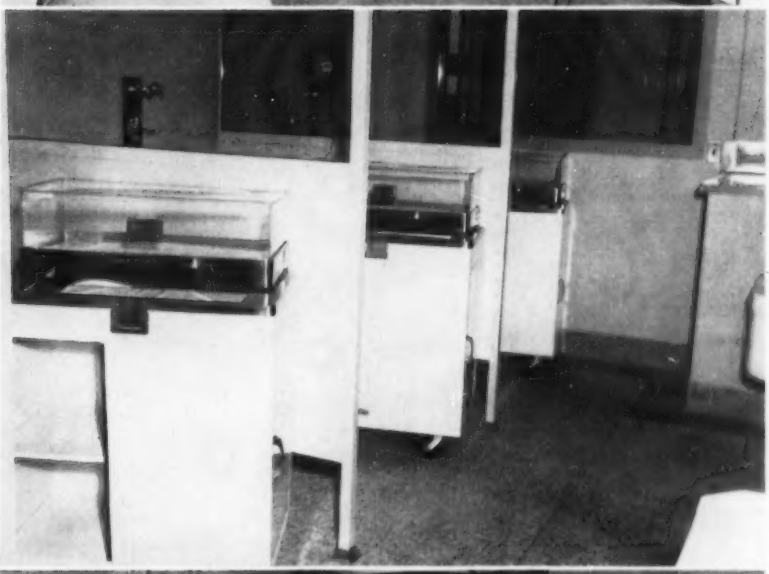
McKeller General Hospital
Fort William, Ont.

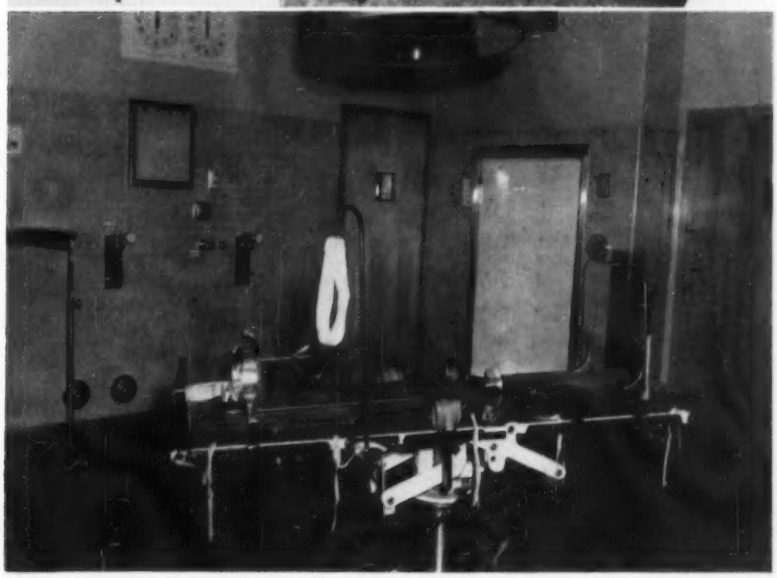
This picture of the kitchen shows the pressure cooker with three ovens in the foreground and the four soup kettles beyond.



Basement

Architects: Govan, Ferguson, Lindsay, Kaminker, Langley, Keenleyside, Toronto.



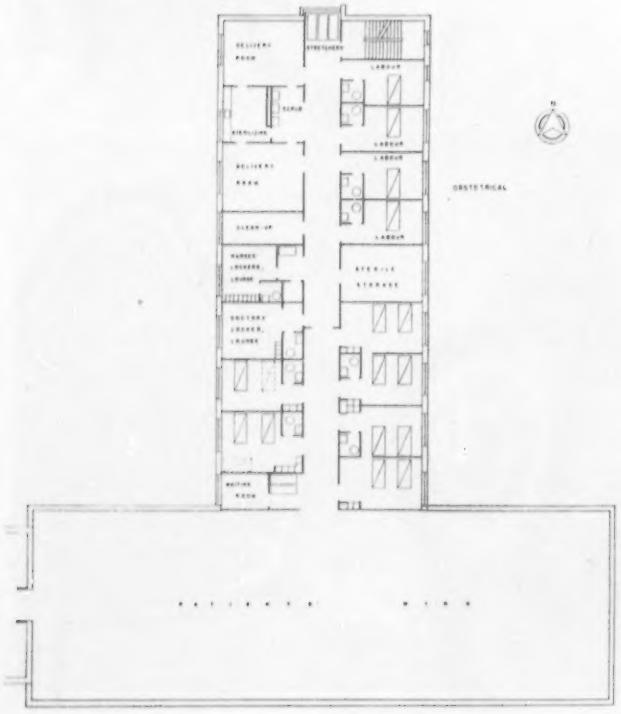


Above: One of the comfortably furnished waiting rooms.
Centre: A typical nursery unit.
Below: One of the four operating rooms.

McKellar General Hospital,
Fort William, Ont.

First Floor

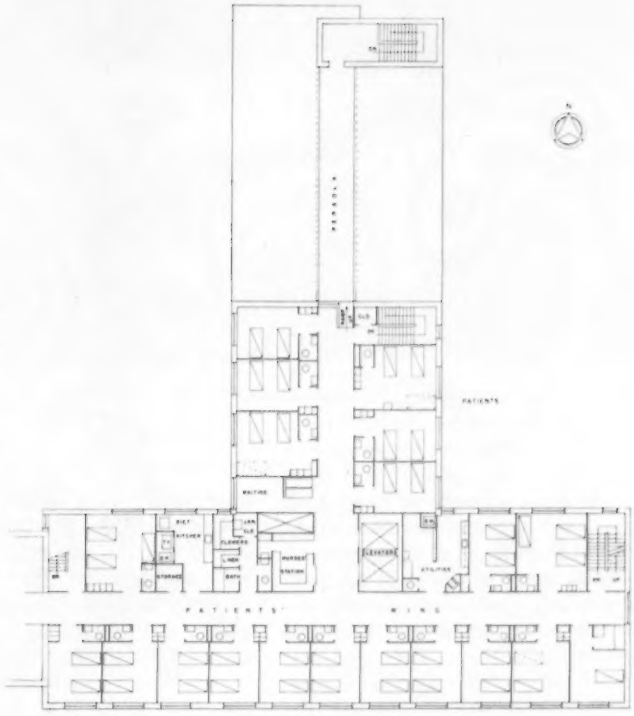
Second Floor



patients and is placed to give the maximum amount of southern sunlight to the greatest number of patients. The wing, at right angles forming the leg of the T, contains the auxiliary service departments — operating and obstetrical suites, x-ray department, et cetera. As the patient wing expands laterally to take care of an increased patient load, the service wing can also expand laterally to provide increased services. At the intersection of the two wings is the traffic and service hub—elevators, dumb-waiters, kitchen, utility rooms, et cetera.

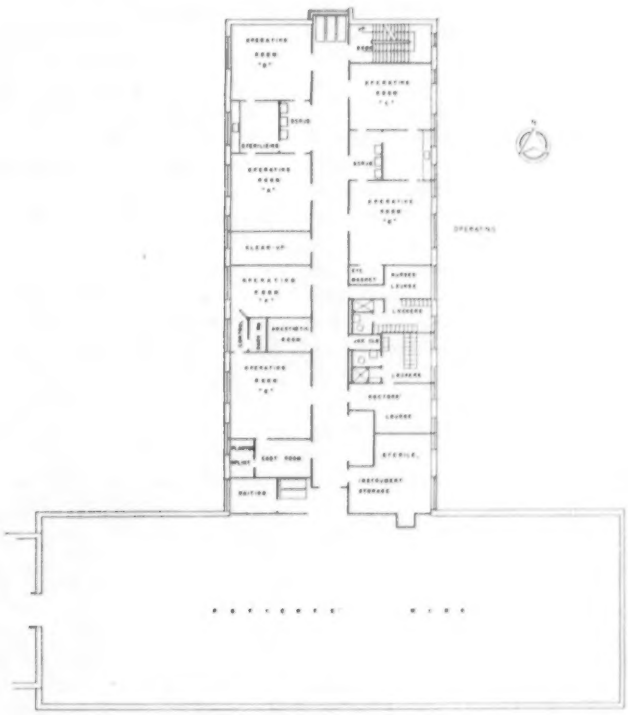
Centred around this hub in the basement are the centralized departments of the hospital—main kitchens, dining rooms, and central supply. Since the food service is centralized, the trays are prepared in the main kitchen, conveyed by means of a traveyor to the dumb-waiter which carries them to the serveries on the various floors. A

Architects: Govan, Ferguson, Lindsay, Kaminker, Langley, Keenleyside, Toronto.



Third Floor

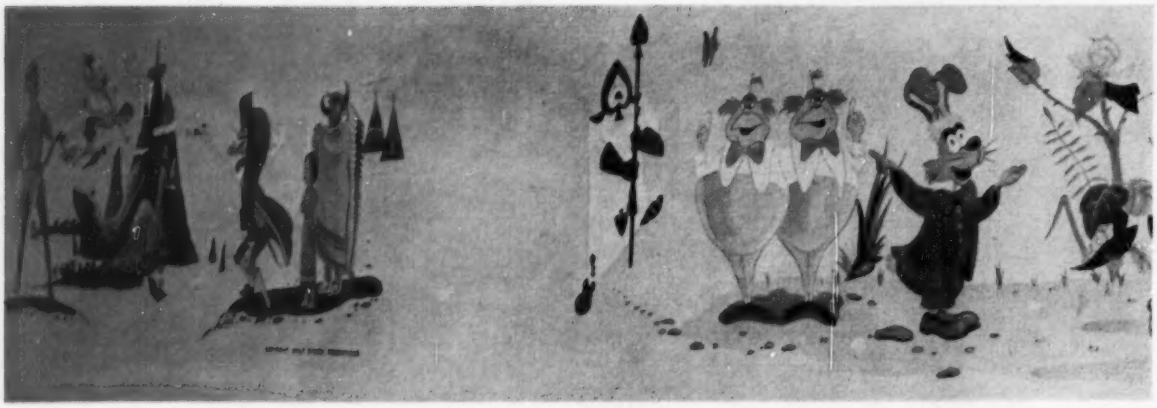
Fourth Floor



dumb-waiter also links the central supply with the utility rooms serving patients as well as the work rooms serving auxiliary departments.

The basement also contains the emergency and pharmacy departments, as well as lockers, rest rooms, and storage area. The treatment room in the emergency department is a dual unit so that two patients can be attended at one time. The emergency department and central supply share a mutual office so that one person can look after both departments at night.

The main wing of the first floor contains the entrance lobby, admitting department and administrative offices. In the service wing is the x-ray department, planned around the latest and most up-to-date equipment, with provision for treating both in- and out-patients. A special room has been built to specifications for the installa-



Gay murals decorate the children's playroom on the paediatrics floor.

tion of a deep therapy unit in this department.

The second floor in the main wing is devoted to patients and the service wing to the obstetrical department. The north-south orientation of the main wing permitted patients' rooms to be placed on the south, while a large part of the northern section contains utility rooms to serve these patients. In these northern latitudes, the psychological benefits of winter sunshine, to be captured only from the south, cannot be over-emphasized. Fort William is blessed with many clear sunny days in the winter time and the hospital has been planned to give the patients the opportunity of enjoying this sunshine.

Throughout the new wing, private rooms have been kept to a minimum. The additional area required for two-bed rooms is not great and the extra potential accommodation thus obtained is a very small factor in the over-all cost. All rooms have their own toilet facilities, equipped with rubber hose for bedpan flushing. Early patient ambulation, the elimination of the corridor "bedpan parade", and the increased flexibility in the use of the room makes this a desirable feature. Suction and oxygen are piped to all patients' rooms as well as to operating and delivery rooms, nurseries, et cetera.

The second floor plan of the main wing is repeated on third, fourth, and fifth floors. This makes for economy as it permits standardization of construction and the stacking of plumbing, one floor over the other. The surgical patients are housed on the third floor, main wing, with the operating suite in the service wing. Medical patients occupy the entire fourth floor and the paediatric department the entire fifth floor.

Above the fifth floor is the penthouse which houses elevator machinery and mechanical equipment; below he basement there is an excavated area to take care of the multitude of pipes required by a modern hospital, and electrical transformers, et cetera. This pipe space is served by the elevators and connects by underground tunnel to the power house where the incinerator is located, thereby permitting garbage trucks to pass back and forth, away from regular hospital traffic.

Construction of the building is reinforced concrete frame with exterior walls faced with brick veneer. This was found to be an ideal construction for a cold climate since, unlike steel frame construction, reinforced concrete closes itself in as the building progresses permitting the contractor to stop outside work at any floor level and concentrate on interior construction during the winter months.

Investigation of the soil, before construction began, revealed its poor quality and necessitated the driving of wooden piles. Considerable apprehension was experienced concerning the effect of the noisy pile driver on the patients. Patient reaction, however proved most surprising. Complaints were remarkably few. and, in fact, there was a general desire on the part of patients to get rooms overlooking the construction so that they could see what was going on!

Climaxing a half century of growth and expansion, the new wing provides 167 additional beds, increasing the hospital's capacity to 435 beds when the older parts of the hospital have been renovated. It was built over a period of two and a half years and cost approximately $2,450,000.

Fifth Floor

Fund Accounting

presents a complete financial picture for the public as well as affording a means of administrative control

Walter Dick, B.Comm., C.A.*
Moncton, N.B.

AN AIM of all accounting is to make available to everyone a factual story of financial relationships which may be interpreted readily. In the case of the hospital, "everyone" means the governing board, the administrator, the patient and his agent, the giver of charitable gifts and, of increasing importance, the taxpayer. For this reason, the financial statements and supporting schedules developed should be designed so that everyone may determine to what extent the objects of the activity accounted for are fulfilled.

While today's hospital is entirely different from yesterday's hospital, professionally, administratively, and economically, it is still dedicated to the philosophy of charity. The historical beginning of the hospital as a charitable institution is exemplified in the modern hospital by the prevailing principle that no one requiring care will be denied it because of inability to pay the bill. This principle of free service establishes the grounds for institutional appeals for financial assistance from the public by voluntary contribution and by taxation.

Before the incidence of high income taxation, hospitals sought and were the recipients of many gift dollars. In many instances there were restrictions in the use which might be made of these contributions. This means donations of money or kind were given over in trust to the hospital to be expended for a particular purpose.

The purpose of the trust might limit the use of the principal, and/or income, of the gift to expenditures for buildings, equipment or subsidization of the day-to-day operation of the hospital. In the absence of evidence to the contrary, it may be assumed that the fund accounting currently in use in hospitals originated and was developed to account for voluntary gifts or tax grants in trust.

Over the years, certain legal principles have developed which insist upon the use of more than ordinary care in the handling of trust assets. Hence the need for the type of accounting which most appropriately depicts stewardship of this quality. Fund accounting is most suitable for this purpose.

It is of interest to note that fund accounting is used extensively in trust companies, educational institutions, insurance companies, and governments. Here, as in the hospital, resources are acquired for the most part for a specified purpose and the financial reporting related thereto should reveal the extent to which the purpose is carried out.

Mechanics of Fund Accounting

The Canadian Hospital Accounting Manual, and for that matter all published texts on the same subject, assumes that the reader is thoroughly familiar with double entry bookkeeping techniques. For this reason these treatises on hospital accounting carry little or no description of the mechanics of the fund method of recording and reporting financial transactions.

As inferred above, in indicating where fund accounting is used extensively, it may not be found in commercial enterprise (developing, processing, manufacturing, and trading). Since most accountants are educated for the work in this latter field, they are not familiar with the principles of fund accounting. This situation tends to develop certain apprehensions which result in the current common thought that the *modus operandi* of fund accounting is profoundly involved.

In truth, it isn't.

The word "fund" originated in the French noun "fond" meaning foundation. Strangely enough, we shall see that the word fund preceding the term accounting is aptly applied. The debit and credit principle involved in recording a financial transaction is the foundation of double entry bookkeeping and is, in fact, basic to the fund procedures giving rise to this discourse. The simplest fund consists of a single financial transaction with the double entry phases, a debit and a credit. For obvious reasons the debit value is of the same value as the credit. This in bookkeeping terminology produces a balanced set of figures. Undoubtedly, this single isolated transaction occurred for a particular purpose.

Thus we can say that the characteristics of a fund are that it is an accounting device consisting of related debits and credits maintained in balance and arranged in association in accordance with a purpose.

Because a number and a variety of financial transactions take place in an organized activity, fund accounting does not retain the simplicity suggested here.

In recording and reporting for values pertaining to a particular project, the need for segrated debits and credits in balance calls for a real understanding of the implications of each financial transaction. In other words, the accountant concerned must visualize mentally the relationship and effect of each and every economic transaction consummated. Today, most organized enterprises consist of several definable functions. Naturally each function requires the use of certain of the enterprise's resources. It is the task of the accountant to maintain this functionalized arrangement by keeping the debits and credits for each function in balance, so as to be able to prepare a balance sheet and an operating statement for each function. Under these circumstances, each function becomes an accounting entity comparable to a separate business enterprise. Every accountant knows that when there is a financial transaction between two companies, a complete double entry is made in each company's records. The same type of bookkeeping entries should be made when there is a transaction involving two functions within one organized enterprise. We

**The author is chairman of the Canadian Hospital Association's Committee on Accounting and Statistics and is accounting consultant to the Maritime Hospital Association.*

can say then that within the one enterprise there is a double double entry for a transaction between two functions. This situation can perhaps best be illustrated by example. Suppose Function A made a loan of $100 to Function B in the incorporated company XYZ, then the following entries would be appropriate.

1. In Function A records:

Debit — Due from Function B $100
Credit— Function A Bank Account $100
To record advance to Function B

2. In Function B records:

Debit — Function B Bank Account $100
Credit— Due to Function A $100
To record advance received from Function A

The above journal entries show that the relationship between the two accounting funds is maintained by means of "due to" and "due from" accounts. Because there are increments and diminishments in the resources of any fund, the preparation of a balance sheet and an operating statement for each function is required. In commercial terminology there is a profit or loss; and in non-profit institutions like hospitals, a surplus or deficit, as a result of the measured movement of the resources in each fund. The net worth of the fund is the difference between the assets and liabilities and is perhaps best revealed by means of an equity account. Using the double entry equation, we can say assets equal liabilities plus equity (A=L+E). As is evident we are using E in place of the P (proprietorship) found in the bookkeping formula A=L+P which is included in the opening chapter of most elementary accounting texts.

Experience suggests that the great need is for accountants to recognize the necessity for the double double entry when a financial transaction occurs between funds within an organized entity. Perhaps if the accountant who is addicted to gum chewing, associates the entry with double double mint, the difficulties with this type of bookkeeping entry would disappear.

Applied in the Hospital

In our preceding remarks, hospitals are shown to have obtained gifts and grants for certain purposes associated with providing care for the sick and injured. Furthermore, for reasons of policy and administration, the hospital segregates its economic resources into two main divisions:

1. Those pertaining to the fixed assets—lands, buildings, and equipment.

2. Those required to support the day-to-day operation of the hospital—patients' accounts receivable, inventories, and the like.

For convenience of communication, we place the items in the first division in an accounting entity designated as "plant funds". The direction of the resources of this fund is usually in the hands of the governing board of the hospital. This is so because the governing board obtains the gifts, grants, and borrowings and so has a real and direct responsibility. The items in the second division are grouped in an accounting entity referred to as a "revenue fund". Sometimes it is appropriately enough referred to as a "current fund" or "working capital fund". The reason for the latter terminology is apparent since the resources in this segregation of accounts are used to satisfy current operating needs and to provide the capital necessary to carry patients' accounts receivable and inventories of supplies. It may be noted that the hospital administrator is usually held responsible for the handling of the items in the revenue fund.

In keeping with the thought expressed earlier, the hospital may have sums of money or property received as a donation in trust for certain specified purposes; or the board itself may have placed restriction upon the use of such gifts. To account for these items there are "endowment funds". Here appropriate stewardship accounting is a must in order to be able to comply in all respects, morally and legally, with the trust involved. Within the general group of endowment funds, there may be several individual funds each tagged descriptively with the originating and dedicated purpose.

For convenience in accounting, there may be many other funds besides those already mentioned. Among these are the following.

Sinking Fund — Accountants are usually familiar with this grouping of accounts. Such a fund is maintained to account separately for appropriations of cash made in keeping with a trust indenture connected with the outstanding bonds of the hospital.

Temporary Fund — These are resources set aside temporarily for a specific purpose. At the proper time, the fund will be expended in keeping with the purpose. Sometimes resources are set aside in anticipation of a new building and are described as "new building fund".

Convent Account Fund — In hospitals owned and operated by Religious Orders, it may be convenient to segregate certain resources not directly associated with providing hospital care. In this connection, sisters' salaries may be transferred to this account by the appropriate entries. It follows that expenditure not directly related to hospital care will be accounted for in this fund.

The main thing to observe, in connection with these funds, is that fund accounting is used because there is managerial need to separate resources devoted to a particular and specific purpose.

The mechanics of fund accounting in the hospital are illustrated by the following entries:

Supposition I:

A purchase of securities for the Endowment Fund is made through the Revenue Fund Bank Account in the amount of $10,000. This is followed by reimbursement from the Endowment Fund Bank Account. The applicable entries at the time of purchase are:

Revenue Fund Entry

Debit—Due from Endowment Fund $10,000
Credit—Bank (Revenue Account) $10,000
To record advance for purchase of securities for the amount of endowment (to be reimbursed)

Endowment Fund Entry

Debit—Securities held $10,000
Credit—Due to Revenue Fund $10,000
To record securities purchased by Revenue Fund (advance to be reimbursed)

The applicable entries at time of reimbursement are:

Revenue Fund Entry

Debit — Bank (Revenue Account) $10,000
Credit — Due from Endowment Fund $10,000
To record recovery of amount advanced to Endowment Fund and deposited in Bank.

Endowment Fund Entry

Debit—Due to Revenue Fund $10,000
Credit—Bank (Endowment Account) $10,000
To record reimbursement to Revenue Fund for advance for purchase of securities.

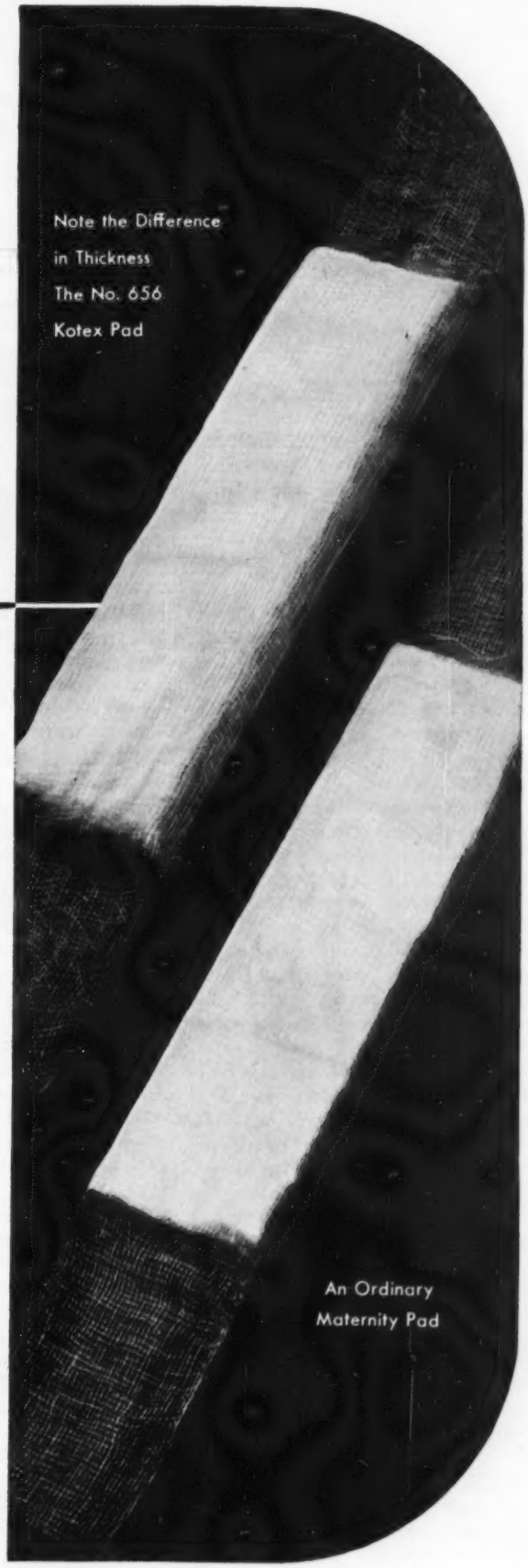
Supposition II:

A hospital is in the fortunate position that depreciation is included in expenditure and the cash in the amount of the depreciation charged in the revenue fund operations is accum-

(Concluded on page 106)

THE NEW IMPROVED

No. 656 KOTEX maternity pad



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Statistically Speaking, 1952

B. R. Blishen, M.A.,
Chief, Institutions Section,
Dominion Bureau of Statistics,
Ottawa.

IN 1953 PUBLIC and private hospitals in Canada were asked to report details of their operations during 1952 on the revised hospital reporting schedules provided by the Bureau of Statistics. Part of the information thus obtained was released by the Bureau last month in Volume I of its *Annual Report of Hospitals* which contains statistics on ownership, bed capacity, medical and nursing education, personnel, hours of work, et cetera. Volume II, to be released within the next few weeks, will contain financial statistics.

Volume I contains statistics reported by 777 public hospitals out of the total of 795 known to be operating in 1952, plus 187 private hospitals, and 42 federal hospitals. Hospitals in every province except Newfoundland reported.

General hospitals with 59,816 beds and cribs accounted for 87.9 per cent of bed and crib capacity in public hospitals, while chronic disease hospitals with 4,818 beds and cribs accounted for 7.1 per cent. No other type of hospital had as much as 2.0 per cent. The total capacity of all public hospitals was 68,033, down from the 68,674 reported in 1951 but up sharply from the 53,938 reported in 1943.

A measure of overcrowding in hospitals can be determined by calculating the ratio of beds set up to bed capacity. Charts, showing the "utilization" ratio, indicate that the number of beds set up per 100 capacity was less than 100.0 in general and chronic disease hospitals, while communicable disease, convalescent and maternity hospitals all exceeded that figure.

Public hospitals reporting approved schools of nursing totalled 153 in 1952, down from the 159 reported in 1951, continuing a trend evident since 1934. Although there were fewer such schools, a total of 4,560 or 9.2 per cent more students were graduated in 1952 than in 1951. Despite this increase, facilities were available for an even larger number of students since the potential yearly graduation of students exceeded the actual number graduated by 1,150.

In order to obtain a more accurate measure of the work load of hospitals, they were asked to report not only the number of personnel in the various occupational classes, as in previous years, but also the paid hours worked during the year. These figures show that graduate nurses' hours were more numerous in the operating room, delivery room, medical and surgical service, direct nursing care, the school of nursing, the out-patient department and the emergency unit. For every 10 hours worked by graduate nurses, 9.8 hours were spent in professional patient care of all types of which 7.0 hours were spent in direct nursing care. The corresponding figures for student nurses were 9.7 hours and 8.1 hours respectively, indicating that, although they spent less time in professional patient care of all types, they spent more hours than graduate nurses in direct nursing care.

The upward trend in admission of adults and children to public hospitals which has been continuous since 1933 was maintained in 1952 showing a 4.7 per cent increase over 1951. There were 1,760,052 admissions representing a rate of 125.3 admissions per 1,000 general population as compared with 123.3 in 1951. Deaths of adults and children numbered 44,674, an increase of 7.5 per cent over 1951. However, the death rate for 1,000 patients under care has declined from a high of 34.9 in 1943 to 24.7 in 1952.

The shortest average stay was reported by maternity hospitals with 8.9 days while chronic disease hospitals had the longest with 311.5 days. General hospitals with 98.0 per cent of admissions to public hospitals had an average stay for adults and children of 10.0 days, up from the 1951 figure of 9.8

With an increasing admission rate to public hospitals has come an increased bed occupancy rate. The precentage occupancy of general hospitals in 1952 stood at 80.2 and was exceeded by chronic disease hospitals with 95.8 and orthopaedic hospitals with 94.5.

Births in public, private and federal hospitals were 80.6 per cent of all births in Canada, up from the 80.2 per cent for 1951. The average stay of newborn in general hospitals was 7.1 days in 1952 compared with 7.3 in 1951.

These are some of the statistics which were reported by hospitals on the revised reporting schedules in 1952. A great deal more information of use to hospital personnel is contained in the report. Some items on the schedules were not reported by a sufficient number of hospitals to make their publication worth while; others were inaccurately reported. It is hoped that these factors will be overcome when the 1953 returns are completed. In addition, if hospitals can forward their returns to the provincial government before the dates specified on the schedules, Volume I of the *Annual Report of Hospitals* for 1953 will be published before the end of August and will be followed by Volume II before the end of October.

* * * *

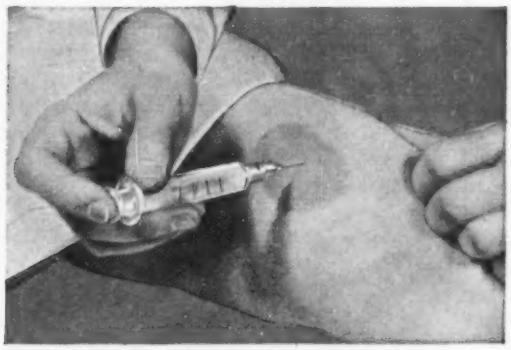
Traduction

Les hôpitaux publics et privés du Canada ont été priés en 1952 de faire connaître les détails de leurs administrations respectives au moyen d'une formule de rapport revisée que leur a fournie le Bureau fédéral de la statistique. Une partie des renseignements ainsi obtenus a été publiée le mois dernier dans le 1er volume du *Rapport annuel des hôpitaux*. Celui-ci contient la statistique relative à la propriété, à la capacité en lits, à l'enseignement de la médecine et de la science infirmière, au personnel, aux heures de travail, et caetera. Le second volume, qui sera publié dans quelques semaines, contiendra la statistique financière.

La statistique contenue dans le 1er volume a été fournie par 777 hôpitaux publics sur un total de 795 en activité en 1952, plus 187 hôpitaux privés, et 42 hôpitaux fédéraux. Chaque province, sauf Terre-Neuve, est représentée dans les rapports reçus.

Les hôpitaux généraux, avec 59,816 lits d'adultes et d'enfants, répondent

For the local treatment of individual joints in rheumatoid or osteoarthritis—



Intra-articular Injection of Saline Suspension of

HydroCortone

ACETATE

(HYDROCORTISONE ACETATE MERCK)

Brown, *et al.*,[1] administered 3,487 intra-articular injections of HYDROCORTONE Acetate to 480 patients with rheumatoid or osteoarthritis. In some of these patients, HYDROCORTONE was used in addition to other therapeutic measures and proved an excellent adjunct. Improvement was observed in 87 per cent. Local relief was obtained promptly, without systemic effects.

Literature on Request

1. Brown, E. M., Frain, J. B., Udell, L., and Hollander, J. L.: Paper presented at Annual Meeting, American Rheumatism Association, Chicago, Ill., June 6, 1952.

HYDROCORTONE *is the registered trade-mark of Merck & Co. Limited for its brand of hydrocortisone. This substance was first made available to the world through Merck research and production.*

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de 87.9 p. 100 de la capacité en lits d'adultes et d'enfants dans les hôpitaux publics, tandis que les hôpitaux pour maladies chroniques, avec 4,818 lits d'adultes et d'enfants, en absorbant 7.1 p. 100. Aucun autre genre d'hôpital n'en absorbe 2.0 p. 100. La capacité totale de tous les hôpitaux publics a été de 68,033, diminution au regard des 68,674 lits déclarés en 1951, mais augmentation marquée sur les 53,938 déclarés en 1943.

On peut obtenir une mesure de l'encombrement des hôpitaux en calculant la proportion de lits dressés par rapport à la capacité en lits. Le rapport contient des diagrammes qui font voir ce quotient d'"utilisation", celui-ci indiquant que le nombre de lits dressés par centaine de lits de la capacité théorique a été de moins de 100.0 dans les hôpitaux généraux et les hôpitaux pour maladies chroniques tandis qu'il a été de plus de 100 dans tous les hôpitaux pour maladies contagieuses, de convalescence et de maternité.

Les hôpitaux publics qui ont déclaré des écoles d'infirmières approuvées étaient au nombre de 153 en 1952, diminution sur les 159 déclarées en 1951 et continuation d'une tendance observée depuis 1934. Bien que ces écoles aient été moins nombreuses, 4,560 étudiantes ou 9.2 p. 100 de plus qu'en 1951 y ont obtenu leurs diplômes en 1952. En dépit de cette augmentation, un plus grand nombre encore d'étudiantes auraient pu se prévaloir de ces avantages puisque le nombre annuel possible de diplômées est de 1,150 de plus que le nombre réel.

Afin d'obtenir une mesure plus exacte de la somme de travail accomplie dans les hôpitaux, ceux-ci ont été priés de déclarer non seulement les effectifs dans les différentes catégories de profession, comme par les années passées, mais aussi les heures de travail rémunérées durant l'année. Les chiffres font voir que les heures de travail des infirmières diplômées ont été plus nombreuses dans les salles d'opération, les salles d'accouchement, les services médicaux et chirurgicaux, le soin immédiat ou personnel des malades, à l'école d'infirmières, au dispensaire et dans les services de soin d'urgence. Sur 10 heures de travail contribuées, les infirmières diplômées en ont consacré 9.8 au soin professionel des malades de tous genres, dont 7.0 au soin personnel. Les chiffres correspondants pour les élèves infirmières ont été respectivement de 9.7 et 8.1 heures, ce qui indique que si elles ont consacré moins de temps au soin professionel des malades de tous genres, elles ont consacré plus d'heures que les infirmières diplômées au soin direct ou personnel des malades.

La tendance à l'augmentation observée depuis 1933 dans le nombre des adultes et des enfants admis dans les hôpitaux publics s'est maintenue en 1952, où l'on a enregistré une augmentation de 4.7 p. 100 sur 1951. Les admissions ont été de 1,760,052, ce qui répresente un taux de 125.3 admissions par millier d'habitants au regard de 123.3 en 1951. Il y a eu 44,674 décès d'adultes et d'enfants en 1952, augmentation de 7.5 p. 100 sur 1951. Toutefois, le taux des décès par millier de malades en soin a fléchi d'un haut de 34.9 en 1943 à 24.7 en 1952.

Ce sont les hôpitaux de maternité qui déclarent le séjour moyen le plus court, soit 8.9 jours, et ce sont les hôpitaux pour maladies chroniques qui déclarent le plus long, soit 311.5 jours. Les hôpitaux généraux, qui représentent 98.0 p. 100 des admissions dans les hôpitaux publics, déclarent un séjour moyen de 10.0 jours chez les adultes et les enfants, augmentation sur le chiffre de 9.8 en 1951.

Le taux des admissions augmentant dans les hôpitaux publics, il s'en suit que le taux des lits occupés augmente aussi. Le pourcentage de lits occupés dans les hôpitaux généraux en 1952 s'établissait à 80.2 p. 100 et n'était surpassé que par celui (95.8) des hôpitaux pour maladies chroniques et par celui (94.5) des hôpitaux d'orthopédie.

Les naissances dans les hôpitaux publics privés et fédéraux représentaient en 1952 80.6 p. 100 de toutes les naissances au Canada, augmentation au regard du chiffre de 80.2 p. 100 en 1951. Le séjour moyen des nouveau-nés dans les hôpitaux généraux a été de 7.1 jours en 1952, au regard de 7.3 en 1951.

Ce sont là certains des renseignements statistiques que les hôpitaux ont fournis en 1952 sur les formules de rapport revisées. Le rapport lui-même contient une somme beaucoup plus considérable de renseignements utiles pour les personnels des hôpitaux. Certains des articles de la formule n'ont

(suite à la page 78)

Officers of the Catholic Hospital Conference of Alberta

Photographed at the annual meeting (see Dec. issue, p. 78) are, front row, left to right: Sister Helen, St. Joseph's Hospital, Barrhead, president; Sister St. Rodolphe, Misercordia Hospital, Edmonton, secretary-treasurer; Sister Zink, Our Lady's Hospital, Vilna, vice-president; Sister Beatrice, St. Michael's Hospital, Lethbridge, Chairman of committee on nursing.

Second row, left to right: Rev. MacKay, Canmore, Bishop's representative; Sister Adele, St. Mary's Hospital, Camrose, chairman of committee on administration; Sister John of the Providence Creche, Calgary, 2nd vice-president; Chief Judge N. V. Buchanan, president of the Associated Hospitals of Alberta; Margaret Foley, Reg.N.; and Rev. Henri Légaré, O.M.I., Ottawa, executive director of the Catholic Hospital Council of Canada.

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Gluten-free Diet in the Malabsorption Syndrome

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Dept. of Therapeutics,
University of Toronto,
Toronto, Ont.

"MALABSORPTION syndrome" is a term that is now used to describe a group of conditions which include coeliac disease in infancy, tropical sprue, and primary and secondary steatorrhoea in adults. It is probable that all these diseases have a similar type of disturbance in the function of the bowel, although this disturbance may be arrived at by different ways and different causes. They are all characterized by diarrhoea, distention of the abdomen with gas, and considerable degrees of weight loss.

When one comes to consider the nature of the defect in function which is present, one learns first that fat absorption is impaired. This disturbance is common, although not entirely constant in its occurrence, and amounts to a failure to absorb anywhere from 30 to 50 per cent of the fat which is eaten. At first, this was considered to be a central, and possibly the only, defect which was present in the diseases mentioned. However, many of the symptoms which occur are not closely related to the degree of fat absorption and they may vary independently of it.

It may be of interest to enumerate some of the complications of these diseases which occur, either singly or in groups, according to the severity of the case and possibly because of the operation of other factors. They include weight loss which may have its basis not only in a loss of calories because of poor absorption but also because the patient loses appetite and eats less. This, in young, growing children, will be accompanied by a failure of growth development. Weakness and prostration are often severe symptoms and may be related not only to the caloric deficit but also to losses of electrolytes and fluids.

These same factors may cause the patient to have a low blood pressure. Two types of anaemia may occur which are due to failure to absorb iron, on the one hand, and failure to absorb vitamin B_{12} and folic acid, on the other. Some patients suffer from tetany, due to a low blood calcium. This causes them to have curious muscular spasms, numbness, and tingling of their skin at times. These symptoms may be due to failure of absorption of calcium but, more probably, they are due to the failure of absorption of vitamin D. This condition may develop to a point which produces changes in the bones with bone pains, fractures, and deformities.

Patients are sometimes subject to episodes of bleeding due to failure of vitamin K absorption. Oedema of the legs may be due to fluid retention and it is found that the serum proteins are very low in patients who have this symptom. Signs of vitamin B deficiency with neuritis, curious rashes, and changes in the tongue, may also appear. Many of these patients show pigmentation of the skin and clubbing of the fingers. Chemical studies often reveal severe depletion of sodium and potassium in the body with a train of symptoms following on these changes. Patients who fail to absorb vitamin A will suffer from night blindness and it is rather curious that this symptom appears to be unusual in a large group of patients.

When one comes to analyze the means by which all these different complications are produced, one sees that they are not only defects of fat absorption but also evidence of impaired protein absorption, carbohydrate absorption, absorption of salts such as calcium, sodium, potassium, iron, and poor absorption of water and vitamins. Hence the new name (malabsorption syndrome) which indicates that it is a multiple defect of absorption and is, therefore, more exact—although it is a good deal more vague at the same time. This vagueness reflects our ignorance about the nature of these diseases.

When one comes to study, by various means, the cause of the disturbance, one finds clues which are sometimes helpful but no final explanation for what goes wrong. In the secondary types of steatorrhoea, changes in the small bowel, due to inflammation with lymphatic blockage, short-circuiting operations or operations which remove a large portion of the small bowel, all indicate various obvious mechanisms by which absorptions may be interfered with. However, they throw little light on the nature of the disturbance which occurs when none of these lesions can be found.

When the bowel is examined in the primary types of steatorrhoea it may show no changes whatever even on the closest microscopic examination. If the patient has been severely ill for a longtime and is very wasted, the intestine may also be thin and wasted. However, in most cases, nothing can be seen. When the bowel is studied by x-ray, giving the patient a drink of barium suspended in water, curious clumping and settling out of the barium occurs. This suggests that the main difficulty may be in the type of mucus which is secreted by the intestine and a sort of clotting process which may interfere with the normal emulsification of foods and, therefore, with their absorption. On the other hand, bacteriological studies indicate that since these people have a very low acid content in the stomach juice, bacteria may grow higher up in the

An address presented at the dietetic section of the Ontario Hospital Association Convention, Toronto, October, 1953.

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smaller bowel than they normally do; and types of bacteria may become established there which do not belong in that area. It is possible that these, either by competition with the patient's absorption or by alteration of the food in such a way as to produce irritating products, leads to a failure in absorption. Chemical studies have indicated that phosphorylation of food stuffs may be very important as a step in their absorption and this may be interfered with in this disease. Direct studies have shown that sugar absorption is poor and the fact that so much gas is produced seems to indicate that some sort of fermentation of starches and sugars may go on and play a part in the production of symptoms. Finally, of course, there is the possibility that some disturbance in the function of the actual cells themselves occurs, which we cannot detect by means of our present techniques of examination.

When one studies the various therapeutic approaches to the problem with a view to seeing what light they may throw on the nature of the disease, one finds difficulty in interpreting the results. It seems likely that the disease process is really made up of a number of interlocking abnormalities and that correction of one of these may do a great deal toward correcting all the others without necessarily proving that the one corrected was the most important one. They also find that patients improve spontaneously when they come into hospital, that their disease varies a good deal with the seasons, and that they respond greatly to interest and understanding on the part of the doctor, who finally comes to a diagnosis on their case and embarks enthusiastically on a course of treatment.

Dietary Therapy

The first approach to treatment appears to be dietary therapy. The diet which has a low fat intake of the order of 50 grams, an increased protein intake up to 100 grams, if possible, a low content of starch but with carbohydrates in the form of sugars, and a low cellulose content, will often produce quite a satisfactory alleviation of the patient's bowel symptoms. In addition to this, one needs to have the vitamins, minerals, and haematinics which are indicated by the investigations of the patient's deficiencies. However, it is very difficult to make a patient gain much weight on such a diet because there are too few calories and the diet tends to seem unpalatable and unnatural to the patient. Milder cases may do quite well on this diet but the severer cases may not make much progress.

The next step was to add a detergent such as Tween 80 to emulsify the fats, improve their absorption and, therefore, allow a larger ration of fat to be given in the diet. It was found that this sometimes did improve fat absorption but that the multiple defects still remained. Some patients were helped and other were not. When cortisone came along it was natural to see what its effects would be because, in the first place, it was believed that the adrenal hormones had something to do with phosphorylation and might, therefore, have a part to play in absorption; it is probably more true that, since it seemed to have a good effect in such a great number of diseases, one felt justified in trying it on almost any condition in the hope that it might help. Cortisone did produce a remarkable improvement in most patients but the nature of its action is still not understood. It may have an effect on the mucosal cells or it may act by correcting some internal metabolic defect. The patients felt well, they gained weight, they were able to take a full diet, and it was possible to show that both fat and carbohydrate absorption were improved. However, there were some failures.

Starch

In the past few years there has been a considerable amount of argument about the place that starch has in the production of symptoms in this disease. When children with coeliac disease were fed starch and their fat absorption measured, it was found that wheat starch and rye starch especially caused an increase in their fat excretion, whereas starch from potatoes, et cetera, seemed to have little effect. It, therefore, appeared that there was some special component of wheat and rye starch which was causing the difficulty. This was found to be the protein in the starch which is called gluten. This is an extremely viscous adhesive sort of substance and is used to make paste. It is the material in flour which allows bread to have its elastic texture and it can be removed from wheat flour to make what are called gluten-free wheat starch granules. This material comes either as a coarse granular powder or as a fine powder.

When one came to apply this new information to treatment, two possibilities existed. The first was to give a diet in which no cereal grains, especially wheat and rye products, were given. The other was to use gluten-free starch and other types of starch such as soya flour, rice flour, arrowroot flour, potato flour, as substitutes for the ordinary types of flour.

The first technique had already been used a long time in treating infants with diets composed largely of bananas, fruit juices, et cetera. However, it is difficult to treat an adult along these lines because so many foods are excluded. It may be of interest to point out some of the hidden sources of wheat flour in our diet. These include: canned cream soups, many types of commercial candy, ice cream, gravies and sauces, meat loaf, bologna, wieners, fish paste, catsup, tomato sauce, mustard, mayonnaise, salad dressing, malted milk, yeast cakes, chewing gum, ovaltine, and some other beverages of a similar type. The obvious sources — bread, pastries, macaroni, wheat cakes, and so on— need no emphasis but all these exclusions tend to make the diet monotonous. It is very important that the exclusion of gluten be complete because a very small amount may produce a relapse of symptoms or interfere with weight gain and growth.

It would, therefore, appear better to make use of these gluten-free starch products wherever they can be substituted. There are a number of these products on the market and they are reasonably priced. The difficulties in the use of gluten-free starch products consist in their lack of cohesiveness. Thus bread and cakes which are made from them are extremely crumbly and have a tendency to taste flat and chalky. The incorporation of small amounts of soya flour may give a moister and creamier texture but large amounts are not very palatable. It is often a help to add dates, raisins, spices, and orange rind to the recipes to add moisture and to give them more definite flavour. Probably, it is wise to let products made of this material stand overnight before they are cut. Details of many recipes, which form at least a basis to work

(*Concluded on page* 110)

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Provincial Notes

British Columbia

NANAIMO. The board of directors of the Nanaimo Hospital have announced plans for a 50-bed addition to the hospital. The addition will include provision for new x-ray, laboratory, and operating room facilities, as well as a new kitchen, dining room, and storeroom. The architects are Gardiner, Thornton, and associates, of Vancouver.

* * * *

PRINCE RUPERT. The board of directors of the Prince Rupert General Hospital has endorsed a recommendation of the finance and long-range planning committees to renovate the top floor of the hospital to make room for a new x-ray unit and an additional nine beds. Cost of the x-ray unit, including a combination radio-graphic and fluoroscopic x-ray table, will be more than $20,000 and the renovation work will cost $35,000. Renovations to the top floor will also provide space for a laboratory, pharmacy, and central sterile supply.

* * * *

SALMON ARM. Tentative plans are being drawn up for the proposed construction of a new 50-bed hospital here. It is expected that the building would cost between $750,000 and $800,000 and would be designed so that an additional 25 beds could be added as the need arises. The proposed site is on three acres of land, behind the present hospital, which have already been purchased.

* * * *

VICTORIA. Construction is expected to begin shortly on a new 50-bed wing to the Pearson Tuberculosis Hospital. The $500,000 wing will be used for the treatment of long-term patients with poliomyelitis but is not intended for patients in the acute stages of the disease.

Alberta

CALGARY. An $80,000, 20-room psychiatric ward has been opened at the Calgary General Hospital. The ward consists of four single "quiet" rooms, 16 standard ward rooms, a parlor, and one "gathering" room. The ward has its own admitting entrance and nursing station.

* * * *

GRANDE PRAIRIE. A $16,000 program for the purchase of new equipment to replace or supplement existing facilities has been approved by the Grande Prairie Municipal Hospital Board. The equipment will include a new x-ray unit, an electro-cardiograph, and a new laundry unit.

Saskatchewan

YORKTON. A portable model respirator is being donated to the Yorkton General Hospital by the Yorkton branch of the Canadian Legion. The equipment is valued at $2,290.

Manitoba

DELORAINE. A capital liability of $183,000 is to be assumed by the newly organized Deloraine Hospital District for the construction of a 16-bed hospital here, a 10-bed medical nursing unit at Melita, and a four-bed nursing station at Waskada. Total estimated expenditure, for facilities proposed in the plan, is $275,000. Of this amount $83,000 will be contributed in federal and provincial grants, and $3,000 by the Manitoba Pool Elevators. The hospital district includes the towns of Deloraine, Melita, the villages of Waskada and Napinka, the rural municipalities of Winchester, Brendam, Arthur, Edward, and part of the municipality of Albert.

Ontario

BLIND RIVER. Construction is expected to get underway this spring on a new 30-bed wing for St. Joseph's Hospital. This hospital provides medical services to people from Iron Bridge to Massey and to the lumber companies, miners, and tourists in the area.

* * * *

ESPANOLA. Work is progressing on the new Espanola General Hospital, which is expected to be ready for occupancy early this summer. The new 35-bed, $300,000 hospital will replace the present 21-bed hospital, which has served the community for some 35 years. The present hospital was first operated by the Spanish River Company, then by the Abitibi Company, and still later by the Red Cross Society. It was operated by the Red Cross as an outpost hospital until 1950 when a local hospital board was set up.

* * * *

OSHAWA. The Oshawa General Hospital will launch a campaign shortly to raise funds to help cover the cost of financing the construction of a new wing and additional service buildings. The objective of the campaign will be in the neighborhood of $1,000,000. Estimated costs for the addition of 132 beds and for the expansion of the kitchen, laundry, heating system, emergency facilities, x-ray department, operating room, and laboratory, has been placed at $2,225,000. Ratepayers have voted in favour of a debenture issue of $850,000, grants from the federal and provincial governments would be approximately $275,000, and the county council has agreed to make a contribution of $90,000.

* * * *

OTTAWA. The new East Lawn Pavilion of the Ottawa Civic Hospital was officially opened recently. The pavilion is a utility building with 78 beds, part of which is being used for isolation cases. Of the 78 beds in the building, 19 are located on the main floor and will be used for the treatment of communicable diseases; 30 beds on the second floor will be used primarily for convalescent patients; and the 29 beds on the third floor include 10 in the recovery room, adjacent to the operating room. Space has been allotted on the ground floor for the admitting department and an out-patient clinic, as well as lockers and storerooms.

* * * *

PETROLIA. The new central heating plant and laundry at the Charlotte Eleanor Englehart Hospital will be

(Concluded on page 108)

Lederle Laboratories carries on intensive research in the field of nutrition and offers the hospital and the medical profession an unusually wide variety of vitamins and protein concentrates. In the photograph above, taken in Lederle's Pearl River, N.Y., laboratory, vitamins are being concentrated in a "counter-current distribution" apparatus. Lederle Laboratories is one of the world's largest organizations for the development and preparation of pharmaceuticals, biologicals, diagnostic, allergenic and vitamin products.

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Members of the executive of the Canadian Conference of Catholic Schools of Nursing, left to right: Sister St-Louis Marie, Quebec; Sister Marion Estelle, Halifax; Rev. Father Henri Légaré, O.M.I., executive director of the Catholic Hospital Council of Canada, Ottawa; Sister Denise Lefebvre, chairman of the conference, Montreal; Sister Mary Beatrice, Lethbridge, Alta.; Sister Delia Clermont, St. Boniface, Man.; and Sister Mary Kathleen, Toronto.

First national work conference on

Catholic Nursing Education

Sister Denise Lefebvre
Director,
Institute Marguerite d'Youville,
Montreal, P.Q.

REPRESENTATIVES of 70 Catholic Schools of Nursing and Schools for Nursing Assistants attended the first national Institute sponsored by the Canadian Conference of Catholic Schools of Nursing, from November 29th to December 4th, held at Maisonneuve Hospital School of Nursing, Montreal. The Canadian Conference of Catholic Schools of Nursing is a permanent committee of the Catholic Hospital Council of Canada. The Institute was directed by Rev. Henri Légaré, O.M.I., executive director of the Council and by the chairman of the conference, Sister Denise Lefebvre, director, Institut Marguerite d' Youville, Montreal.

The six-day session was arranged to provide an opportunity for religious nursing educators throughout Canada to study trends and problems affecting Catholic schools of nursing and to acquaint participants with the national situation regarding nursing education. Some of the topics considered at the meeting included: general formation of students; a study of various educational systems such as two-year programs, and education for auxiliary nursing personnel; the administrative relationships of the school with the hospital; and professional relationships such as with the C.N.A., students' organizations, et cetera.

Sessions were bilingual with an equal number of conferences presented alternately in French and in English. After a general presentation of the basic principles of the subject under study, groups were formed, according to the interests and language of the participants, to consider the same problem in detail. At a general meeting, held at the close of each day, reports from the various study groups were given. "Collaboration" was the watchword of the Institute and all participants were faithfully adherent to it. One could sense the unity of mind and heart of all members.

Among the main conclusions reached by participants at the Institute are the following:

1. The student nurse should be well prepared technically and there should be integrated in her professional education the intellectual, moral, and social formation necessary to render her capable of giving total nursing care to her patients.

2. In order to make students Christian women of character and leaders who will have a leavening influence on their milieu, methods of education should be re-examined and, if need be, a new approach be used to give students increased responsibility in the perfection and practical achievement of the social, cultural, and professional aims of the school. In many schools, a student organization has proved helpful in developing these aims.

3. Since a complete education of the student is impossible without a sound religious and moral foundation, the Sisters re-emphasized the importance of such formation in preparing the nurse to play her role in modern society and to exercise a Christian influence in a world imbued with materialistic philosophy.

4. From general observation, the group concluded that the true Christian spirit of nursing is not always understood or possessed by modern nurses. It, therefore, needs to be stressed through teaching and example in order that student nurses may learn to give conscientious and devoted nursing care to the whole patient, body and soul, and to do this in a spirit of Christian charity.

5. For the smooth functioning of institutions, the Institute stressed the need for individual development of all personnel concerned and for the proper spirit of co-operation among co-workers both in policy-making and in job-execution. Functions should be clearly defined and lines of authority

(Concluded on page 104)

This is from a report prepared by Sister Denise Lefebvre. The full report will appear in French in the March issue.

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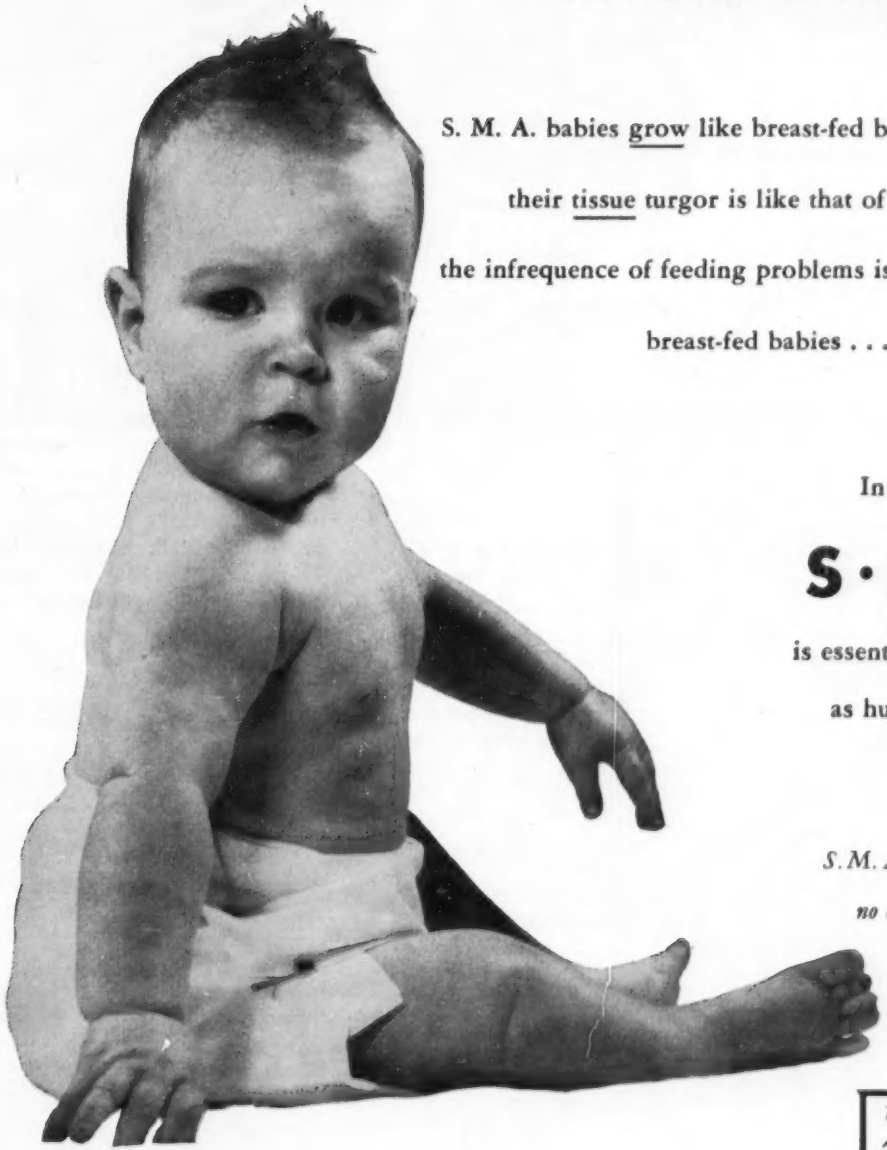

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Year Reviewed by Auxiliary to Jewish General Hospital, Montreal

The year 1953 was a record year in two respects for the women's auxiliary to the Jewish General Hospital, Montreal. First, the auxiliary attained its largest membership with 4,019 members and, secondly, it collected a record $45,823 from dues and donations. During the past year, the life saving fund, which aids indigent patients, collected $21,359. The auxiliary has contributed $25,000 toward new equipment for the premature nursery, located in the new wing which will be opened shortly. Receipts from the nursery fund totalled $5,938 and from this fund the hospital receives $2,500 annually to provide for the needs of the children in the public wards. Layettes are also given to needy mothers leaving hospital and 59 were distributed in 1953.

The gift shop netted $2,500 for the auxiliary and the shop will be moved to more spacious quarters when the new wing is opened. The infant photography group, which photographs newly-born children, made $1,074. New books were also purchased for the medical library. One of the auxiliary's biggest contributions to the hospital is the supplying of linens and surgical dressings.

* * * *

Active Year for Women's Board of Toronto Western Hospital

Opening of the new gift shop was the big achievement of the Women's Board of the Toronto Western Hospital, Toronto, Ont., last year, it was reported at the annual meeting held in December. The shop has proved to be a successful undertaking financially and of great service to both patients and staff.

During the year, library work once again became an important part of the activities of the Women's Board. A new library room was provided by the hospital and a collection of almost new books makes it posible for patients to enjoy the pleasures of library service. Efforts are being made to secure foreign language books, as well as English.

The finance convenor reported that $921 had been raised by means of a fashion show and $403 as talent money. Forty-seven layettes were among articles prepared by the handicrafts department last year.

* * * *

Excellent Year for Vernon Auxiliary

The Women's Auxiliary to the Vernon Jubilee Hospital, Vernon, B.C., has completed an excellent year and has provided the hospital with many pieces of equipment including: a suction and ether pump, an oxygen tent, four electric inhalators, a commode chair, a B.M.R. machine, an instrument sterilizer, and an instrument table. The total cost of this equipment was approximately $1,956. Money was derived from a fashion show, a tea, and a rummage sale. During the Christmas season, the auxiliary also provided and decorated a Christmas tree for every ward in the hospital.

* * * *

First Annual Meeting Held by Auxiliary at Port Perry, Ont.

The first annual meeting of the Women's Auxiliary to the Community Memorial Hospital, Port Perry, Ontario, was held recently. Women from 40 organizations, which comprise the auxiliary, were present. Reports from the various members of the executive were read and a review of the year's work showed that many necessary pieces of equipment had been purchased for the hospital. It was also reported that over 940 articles had been made to stock the linen room. During two months last fall, the women donated over 900 containers of fruit and jam. Last June, members of the auxiliary assumed the responsibility for keeping the linen room supplied, as well as purchasing china and glassware for the hospital.

* * * *

Auxiliary Helps Equip New Wing

Contributions to the fund for equipping and furnishing the new wing at the Norfolk General Hospital, Norfolk, Ont., have been made by the auxiliary. In addition to making a memorial gift of $2,800 to the fund, the auxiliary has also invested the sum of $1,595 in new sewing machines for the workroom at the hospital.

* * * *

Foam Lake Auxiliary reports for 1953

The annual report of the Women's Auxiliary to the Foam Lake Union Hospital, Foam Lake, Sask., reveals that the auxiliary has purchased much needed equipment for the hospital. Among these items were the following: a deep freeze unit, a folding chrome wheelchair, and a piano for the nurses' residence. At Christmas time, small favours and pyjamas were provided for staff and patients.

* * * *

Belleville Auxiliary Opens Canteen

A canteen, known as the "Coffee Snack", was opened by the Women's Auxiliary to the Belleville General Hospital, Belleville, Ont., in January. The canteen operates seven days a week and has aroused much public interest—so much so that the auxiliary membership has increased to such an extent that no difficulty is anticipated in staffing the canteen. Members of the auxiliary have also been active in the hospital building campaign, by canvassing for funds, addressing church and club groups, and giving radio addresses.

* * * *

A Record for Kimberley Auxiliary

The Women's Auxiliary to the Kimberley and District General Hospital, Kimberley, B.C., has established a record as far as membership is concerned. Within six months of its organization, the auxiliary climbed to a membership of 357. According to Mrs. Forbes Perkins, president of the Auxiliaries Division, British Columbia Hospitals' Association, the Kimberley organization has the distinction of being the largest auxiliary in the province and of having become so in the shortest time.

Life is a fragment, a moment between two eternities, influenced by all that has preceded, and to influence all that follows. The only way to illumine it is by extent of view.—*William Ellery Channing*

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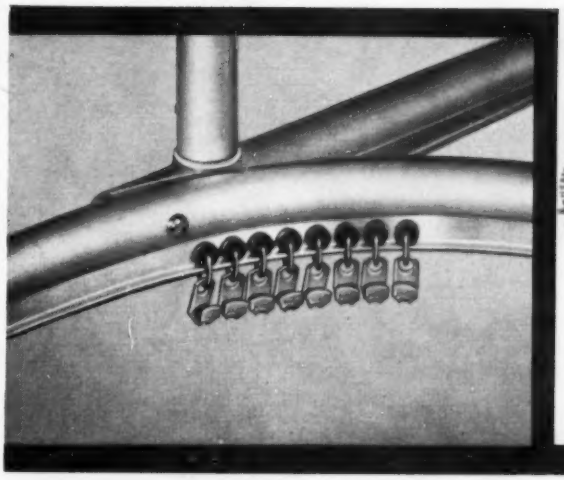

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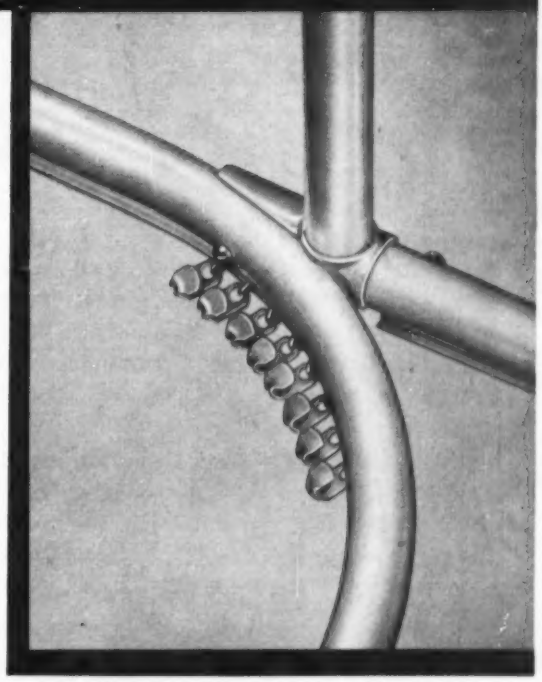

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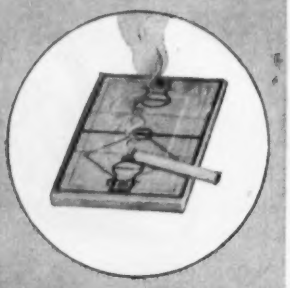

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Book Reviews

CHRONIC ALCOHOLISM AND ALCOHOL ADDICTION. By R. J. Gibbins, research staff, Alcohol Research Foundation, Toronto, Ont. Pp. 57. Price $1.50. Published by University of Toronto Press, Toronto.

Mr. Gibbins, with assistance from B. W. Henheffer and A. Raison, department of psychology, Queen's University, Kingston, Ont., has ably reviewed, classified, and summarized the extensive literature available on alcoholism. Beginning by defining and differentiating chronic alcoholism and alcohol addiction, the author then summarizes the main scientific writings under the headings of etiology, psychological investigation of alcohol addiction, and treatment.

Briefly but carefully done, the book makes interesting reading for any physician, nurse or psychologist desirous of gaining a basic foundation in the subject while a seven-page bibliography provides the serious student with material for more intensive study. The printed pages suffer somewhat for want of more distinctive sectional headings. However, this is a minor fault and the only really disturbing feature to this reader is the lack of a final, organized section for a summary and conclusion on the basis of the author's study.

The section on etiology is particularly rewarding to the reader. The various possible causes are well presented with the apparent conclusion that many etiological factors play a part in producing alcoholic addiction in different patients or in a single patient.

While somewhat barren of positive findings in concluding that there is no such thing as a typical "alcoholic personality", the section on psychological investigations does indicate that various personality tests are of value in diagnosis and treatment. Such tests, therefore, are of little value in prevention but may be of considerable assistance in analyzing the personality structure of alcohol addicts and chronic alcoholics in order to understand the etiology in a given case as a guide to treatment methods.

In his review of treatment, the author points out a finding of particular interest to hospitals. Several studies of short-term treatment in general hospitals were relatively successful. The author suggests that possibly more active participation is indicated for general hospitals in the treatment of alcohol addiction.—*A.L.S.*

REHABILITATION OF THE OLDER WORKER. Edited by Wilma Donahue, James Rae, Jr, and Roger B. Berry. Pp. 200. Price, $3.25. Published by the University of Michigan Press, Ann Arbor, Michigan.

This very interesting book is the record and summary of the Fourth Annual Conference on Aging, sponsored by the University of Michigan. The conference was designed to promote a more general appreciation of the number of older persons who can be served, the best means and techniques for accomplishing the goals of rehabilitation, and the substantial savings in private and public funds that can be achieved through adequate rehabilitation and preventive programs.

Wilma Donahue, Ph. D., is research psychologist and chairman in the Division of Gerontology, Institute for Human Adjustment, lecturer in psychology at the University of Michigan, and was chairman of the planning committee for the conference on the aging.

The conference attacked the problem of rehabilitation of the older worker in various ways by considering the medical aspects, psychosocial and economic phases, employment and placement, and rehabilitation services and programs. Under the section on medical aspects, there is a division on planning hospital rehabilitation programs.

Four types of meetings were included in the conference plan: general sessions, conference board hearings, clinical demonstrations, and group discussions. A unique aspect of the program was that of conference board hearings. Each board was made up of seven persons, representing groups concerned about rehabilitation of the older worker, who were not personally engaged in the area of professional work. At each hearing, a different group of experts was invited to discuss questions posed by the board. The chapters which record these discussions contain very lively and informative reading.

FILMS IN PSYCHIATRY, PSYCHOLOGY AND MENTAL HEALTH. By Adolph Nichtenhauser, M.D., Marie L. Coleman, and David S. Ruhe, M.D., of the Medical Audio-Visual Institute of the Association of American Medical Colleges. Price, $6. Illustrated. Pp. 264. Published by the Health Education Council, New York, N.Y.

In a very complete and interesting fashion, this book presents 51 critical reviews of films in psychiatry, psychology and mental health, supplemented by brief descriptions of 50 additional films available on these subjects, as of January, 1953. Each review contains a description of content and manner of presentation, as well as production and distribution data. Each review ends with a very thorough appraisal, with considerable attention placed on the film's effectiveness in reaching a specific audience. For the reader's interest pictures of dramatic scenes from various films are presented. For quick reference, subject matter is indexed in a way that makes it easy for a reader to judge the actual content of films which often have a misleading or uninformative title; another index offers a "suggested audience guide" for each film. Of special interest to Canadians will be the reviews and pictures of two films produced by the National Film Board of Canada—"Breakdown" and "Family Circles".

In the selection of films in mental health, this book offers very complete and graphic guidance while, at the same time, it is always interesting reading. In addition to the well-written reviews, the authors discuss the value of films in teaching those engaged in mental health work and in reaching more general audiences They show how this medium has been applied to the field of mental health in the past fifty years and suggest how better films can be made on this subject.

When the best things are not possible, the best may be made of those that are. — *Richard Hooker*

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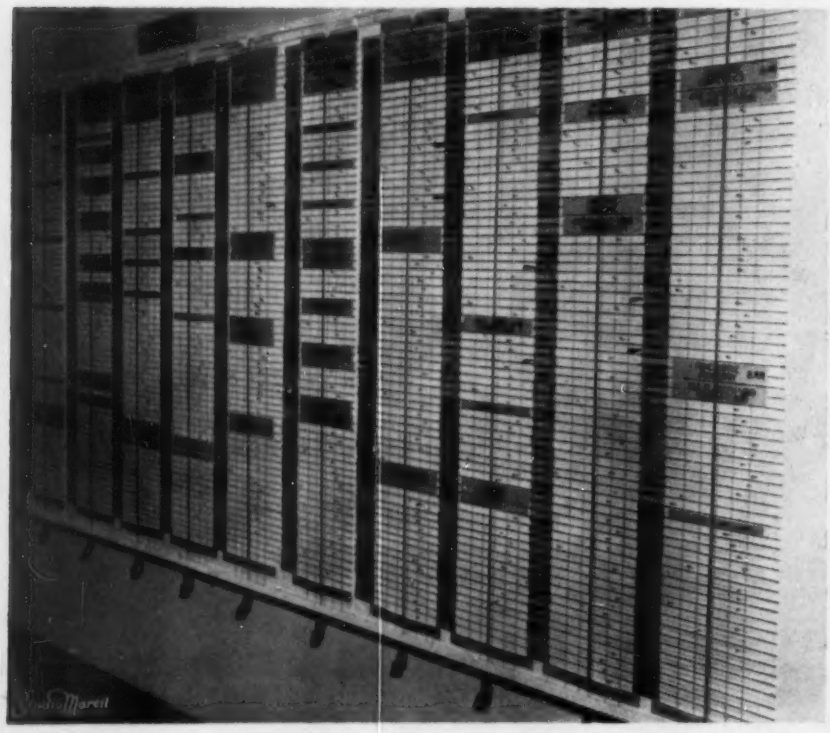
Bed Assignment Control Board

Robert R. Langée, S.B., P.E.,
Industrial-Management Consultant, Ottawa, and Somerville, Mass.

THE PRINCIPAL objective of the bed assignment control board is the complete centralization of bed allocation. By that is meant, that the hospital medical personnel cannot assign a bed nor change a resident patient from one bed to another, without first consulting the control board personnel. The control board produces an exact panoramic view of the occupation of each bed in the hospital with the exception of nursery cribs. Control in all medical service departments is effected through the tentative discharge date of a patient in a particular room and the particular alphabetical letter assigned to the bed considered. The only exceptions to this rule take place in psychiatry and paediatrics where the beds, because of their interchangeable nature, are controlled by patients' names.

Thus, a series of 11 panels for some 600 beds permanently lists each bed during its occupation intervals, the latter being followed up through a series of 31 holes, each hole representing one day of the month. Each panel is about 5′ long and some 10″ wide. A plumb line is made to move daily, ultimately covering a maximum of 31 days in the months having that number of days and stopping at 30 or 28 and 29 days as required, only to start again on the first day of the following month. The control itself is actually effected through the tentative discharge date of the patient as first indicated on the doctor's application form for admission. Thus, if a patient is admitted to the hospital on the fifth day of the month and the said application calls for a hospital sojourn of 10 days, a coloured peg will be inserted in the hole in line with the 15th day of the month date scale and so on for all other patients in the hospital. In order to ascertain as precisely as possible the exact day when a patient is to be discharged and hence permit the process of admitting another patient to start as soon as the plumb line, in its travel en route to the end of the month, has reached within 3 days of the thus pegged tentative date of discharge, *i.e.*, the 12th day in the example above, the control clerk contacts the supervisor in charge of the floor in question and ascertains the actual condition of the patient with respect to discharge time. Should the reply from the supervisor confirm the tentative discharge date, the control clerk is then in a position to assign the bed to the patient whose reservation number has precedence. If the answer of the supervisor is negative, *i.e.*, if the last tentative date of discharge cannot be realized, the aforementioned peg will be moved to a new tentative discharge date. When the plumb line in due course reaches within 3 days of this new date, the control clerk repeats the

(Continued on page 90)



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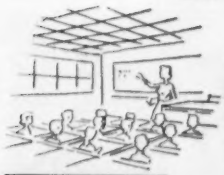

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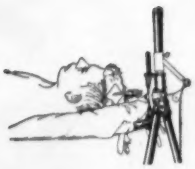

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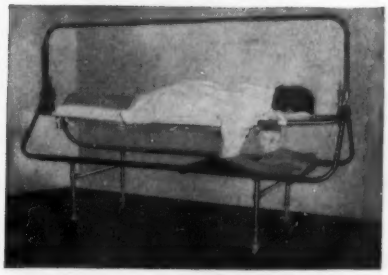
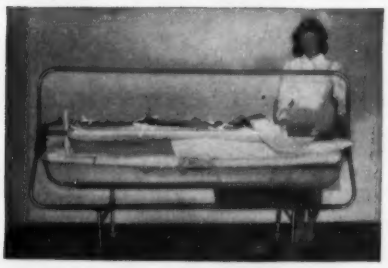
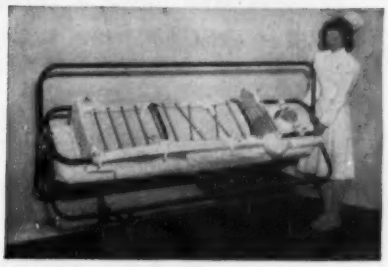


The Stryker Turning Frame is essential for the effective care of immobilized patients. Nursing for cervical fractures, burn cases, paraplegics and patients under continuous traction is quick, easy, without patient disturbance. Treatment of back wounds and burns as well as bedpan service is simpler. Bed sores and the dangers of kidney and bladder stones are largely eliminated.





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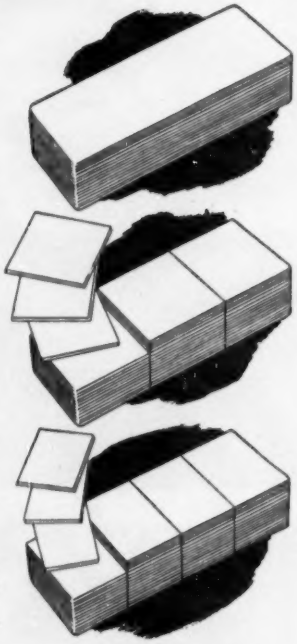

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Challenge and Opportunity

(Continued from page 35)

petition proceeds on a strictly financial basis, some institutions will be forced to close their doors or to merge with stronger hospitals. The more acceptable physicians will soon dominate practice and procedures throughout the community.

The greatest good for the greatest number of physicians and patients can be achieved by voluntary co-ordination. Unless it is accomplished in this way, it will be reached through legislative control, a method generally regarded as second choice to voluntary action in North America.

Conforming to modern trends

Does the hospital's program conform to modern trends in medical practice? The main purpose of a hospital is, of course, to provide good medical care through effective use of professional knowledge, skill, and facilities. But there is frequently a lag between most recent developments in medical knowledge and skill and their application to the needs of a community.

High quality medical care is not completely dependent upon the existence of modern, recently constructed buildings. Everyone is familiar with excellent service provided in outmoded structures. Conversely, the presence of up-to-date equipment does not assure modern professional attention. About five years ago, the writer visited a hospital in which an electro-encephalograph had remained unpacked in the storeroom for two years because no member of the staff was familiar with its method of operation.

Some of the recent trends in medical practice which affect hospital construction and operation may be mentioned to illustrate the appropriate concerns of trustees, medical staffs, and hospital management. These are early ambulation for bed-patients, expansion of out-patient service, growth of physical medicine, and service to the homebound.

Early ambulation is an important part of present medical practice. But the importance derives not only from the additional number of patients who may be served by a hospital but also from the manner in which patients and personnel spend their time. Many in-patients occupy their bed-rooms (not to mention their "beds") for relatively small portions of each day. At noontime they march stolidly back to their rooms, even jump in bed, to await their luncheon trays. Yet much hospital construction and many nursing procedures continue as if the patients spent most of their time in a horizontal position.

Many doctors now refer their private patients to hospital for laboratory tests and diagnostic work-ups. Hospitals have accepted these private vertical patients but have not always received them in adequate waiting rooms nor provided the doctors with suitable space for consultation. Proper scheduling of procedures and consultations for private ambulatory patients is a convenience to the doctor. It also enables the institution to serve a larger portion of the general public with the existing facilities.

Great opportunities for better utilization lie in the growth of physical medicine following surgery or medical treatment of hospital bed cases. Rehabilitation also includes follow-up services of special training and guidance. They should be properly located within the walls of hospitals where

(Concluded on page 100)

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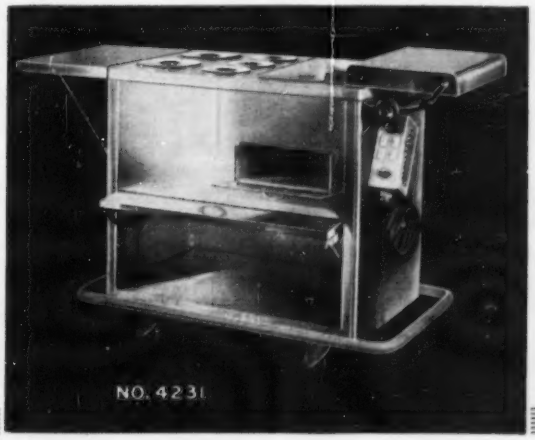

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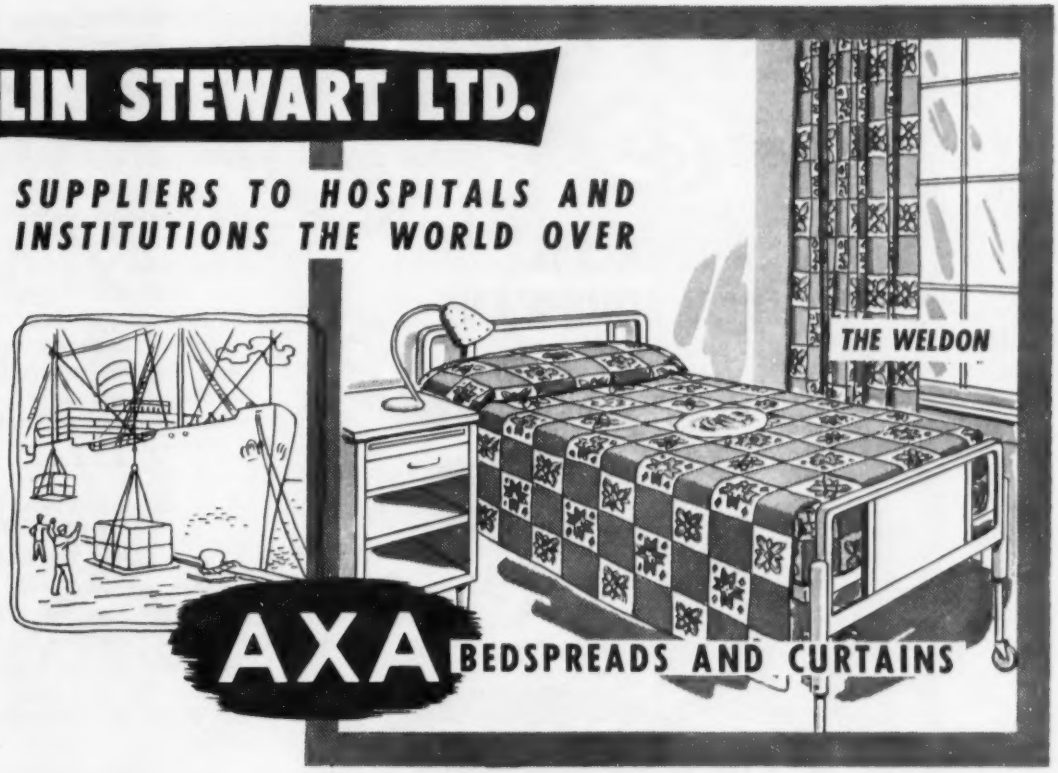

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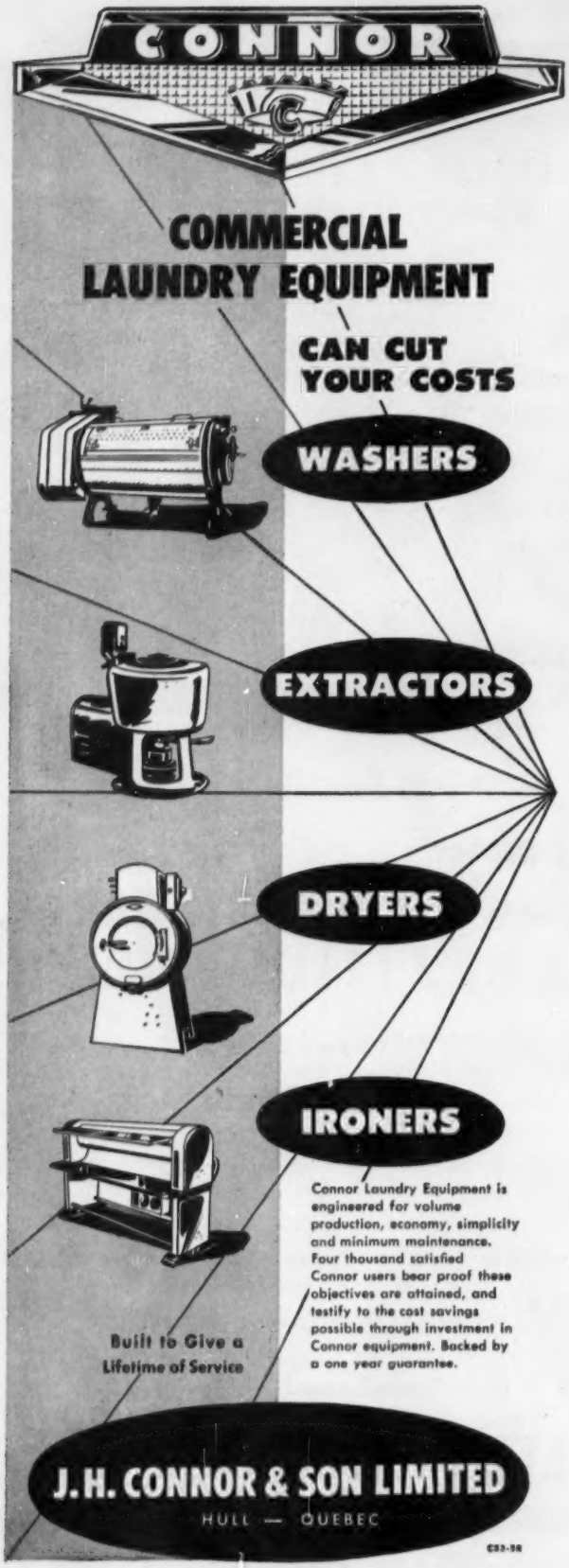

Traduction
(Suite de la page 52)

pas été déclarés par un nombre suffisant d'hôpitaux pour justifier leur publication; d'autres n'ont reçu que des réponses inexactes. On espère que l'on pourra compter ces lacunes lors de la préparation des rapports de 1953. De surcroît, si les hôpitaux peuvent envoyer leurs rapports à leur gouvernement provincial respectif avant les dates indiquées sur les formules, le 1er volume du *Rapport annuel des hôpitaux* pour 1953 sera publiée avant la fin d'août et sera suivi par le second volume avant la fin d'octobre.

Tuberculosis Death Rates Around the World

The Canadian Tuberculosis Asociation has published in its *Bulletin* the death rates from tuberculosis in various countries around the world. The figures were gleaned from the epidemiological and vital statistics report of the World Health Organization for 1952.

United States	16.1
Cyprus	8.0
Philippines (Manila)	178.7
Austria	45.0
Denmark	11.3
Finland	57.2
France	43.0
Ireland Rep.	54.1
Netherlands	12.3
Portugal	95.6
England and Wales	24.1
Scotland	31.3
Northern Ireland	29.8
Switzerland	24.8

The Canadian death rate from tuberculosis for 1952 was 17.1.

Chicken Soup Wears Watercress Well

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After the requisite milk "thinning" has gone into the mixture, heat it slowly until hot, but not boiling. A sprig of watercress placed in the center of each serving of this soup helps to advertise its special character. — *"Institutions Magazine", August, 1953.*

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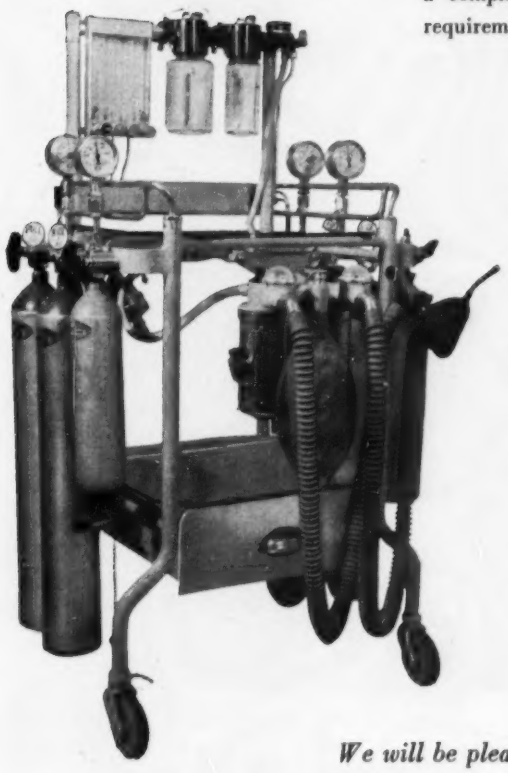

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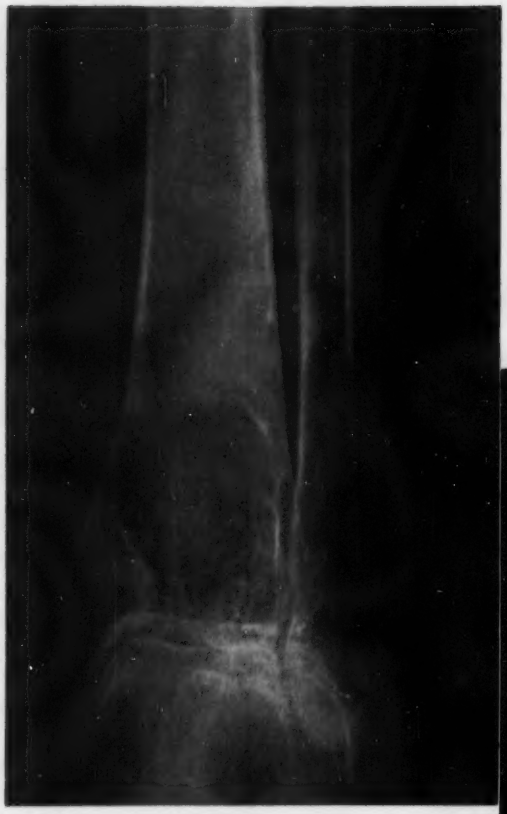

definition
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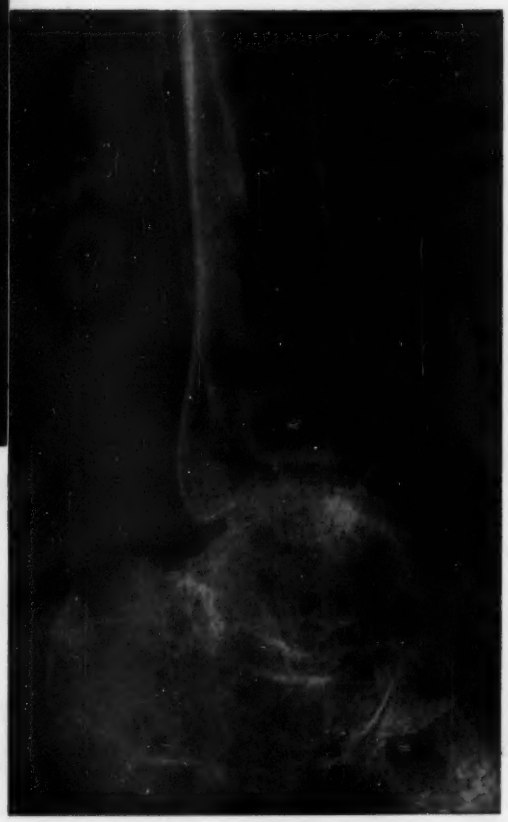

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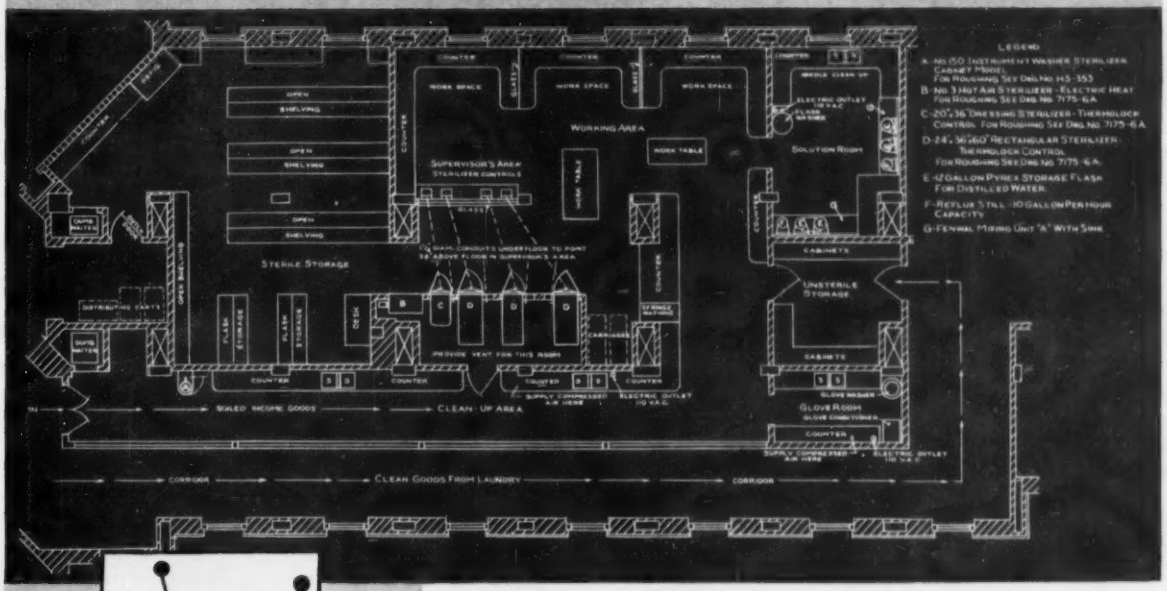

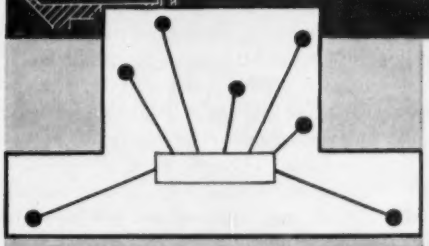

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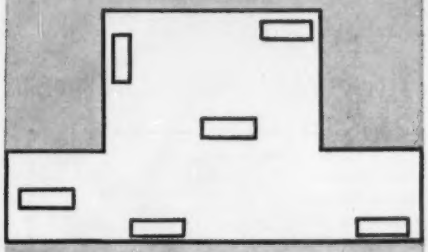

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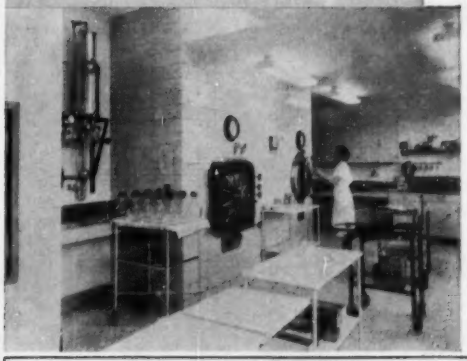

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How to Raise Money

(Concluded from page 38)

issued. Stratford patients represented 60 per cent of the patient-days at the hospital and the balance were from eight or ten nearby municipalities, mostly in the County of Perth.

The city agreed to underwrite its $600,000 share but we were unable to reach agreement on the balance. The annual debenture costs for the $1,000,000 of debentures were going to be about $66,000. Our new hospital, at 75 per cent occupancy, would have about 44,000 patient-days per year; and so we estimated the patient-day cost of building the hospital, as distinct from the cost of operating it, to be about $1.50 per patient-day. We, therefore, proposed to City Council that they underwrite the whole $1,000,000 in debentures but on the understanding that they would only have to repay through taxes 60 per cent of this. The balance, or some $26,000 per year, we undertook to raise and pay to the city treasurer by an extra "equilization charge" of $1.50 per day charged only to patients from outside municipalities using the hospital. City Council and the city ratepayers approved and the plan was instituted. Within a very short time the nearest municipalities having the greatest hospital use had agreed to pay these "equilization charges" through their township councils, rather than having them billed to their residents who had been patients. So, in effect, without the necessity of the outside municipalities issuing any debentures, they are paying their share of the capital costs through their taxes. The plan has been working now for five years. Any early antagonism has long since disappeared and almost everyone concerned agrees that it is a good solution to this particular problem.

Two more points arise from a less satisfactory experience we have had. A year ago we asked City Council to approve a debenture by-law for renovating the old hospital and converting it into a hospital for chronic or long-term patients. City Council agreed to put the question to a vote of the ratepayers. However, probably because they felt it would not be good politics for them personally, they carefully refrained from endorsing the proposition themselves or recommending to the ratepayers that it be passed. A few of the councillors privately opposed the by-law and it was soundly defeated. The matter is coming up again this year and we are hopeful that it will be approved this time. From this experience, however, we have decided that if we cannot sell a proposition to City Council we have poor prospects of selling it to the ratepayers; and we do not want a by-law put to the ratepayers again unless it goes with a public endorsement from City Council and their recommendation that it be approved. Out of that same experience we are convinced that too many figures can becloud an issue rather than clarify it. About the only figures we would use in our publicity again would be the amount requested in debentures and what they would cost per year in taxes on a typical workman's home. We would stress then the need, the service the community would obtain, and the problems of families who are not able to care for their own chronic patients, *i.e.*, the human appeals rather than the monetary ones. Lengthy and complicated tables and explanations of how certain figures are obtained are not effective advertising for a hospital appeal.●

Results Are Better

(Concluded from page 32)

statistics for 1953. This program is ambitious and is a challenge not only to the Bureau but also to the hospitals of Canada. In the final analysis, ultimate success depends upon the hospitals' whole-hearted co-operation.

The statistical reporting schedules from which the report is compiled have been modified and streamlined. There are now two schedules instead of three. The first schedule, containing general information which goes into Part I of the report, should be completed and filed by every hospital by the end of January each year.

If by chance, any hospital has not yet received the forms and a copy of the handbook of definitions and instructions for use in completing the return, these may be obtained, upon request, from its provincial department of health or from the Dominion Bureau of Statistics.—*M.W.R.*

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WHO Holds Asian Malaria Conference

Over 50 participants, from some 20 countries throughout Asia, attended the World Health Organization's first Asian malaria conference, held at Bangkok, Thailand, in September. Delegates met to discuss plans for the elimination of malaria from regions where nearly one-quarter of the world's population lives.

At the inaugural meeting, it was pointed out that malaria is not only a menace to human health but also an economic liability of the first magnitude. However, it was also emphasized that, owing to the rapid advances in scientific knowledge during the past several decades, it is now possible to think in terms of virtually wiping out this disease over wide areas and bring it under effective control throughout Asia within a matter of years.

Dr. Luan Ayurakit, director of the Division of Malaria and Filariasis of the Thai Ministry of Public Health, who was elected chairman of the conference, pointed out that malaria affected over half of the human race rendering many persons weak and ineffective, even when not killing them. In many countries of Southeast Asia there are extensive rice-growing areas and over one billion people depend almost exclusively on rice for their subsistence. Unfortunately, farmers who grow rice suffer most from malaria; effective control was, therefore, one direct way of increasing rice production.

Dr. Lakshminarayana, advisor on Health Programs to the India Planning Commission, spoke on the result of malaria control measures instituted in the Canara District of India in 1946. He said that seven and a half per cent more acreage has been brought under cultivation. On an outlay of 500,000 rupees a year, the economic return is computed at ten times that amount, he reported.

Malaria control in Indian coalfields saved the industry 135,820 man-days during one year alone, it was reported. Further, it is estimated that by controlling malaria in the Malnad area forty million working man-hours will be saved.

Dr. Melvin Griffith, of the United States Foreign Operations Administration in Thailand, stated that it was estimated that malaria costs Thailand a minimum of 10 million man-days annually. The money value of this yearly loss, he said, was sufficient to maintain a permanent malaria control organization in Thailand for some 15 to 20 years.

Civil Defence Grant for Newfoundland

An agreement covering the cost of continuing civil defence measures in Newfoundland has been reached between the federal and provincial governments. Expenditures will total $10,200 for the present year and will be equally shared by the participating governments. This sum will cover administration and organization costs of the Newfoundland provincial civil defence headquarters including salaries, acquisition of materials, supplies, and travel expenses. Newfoundland is the fifth province to take advantage of the civil defence matching funds program.

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Dillon and Murphy, American Journal of Roentgenology and Radium Therapy, LXI, 6, June 1949, pp 847–849.

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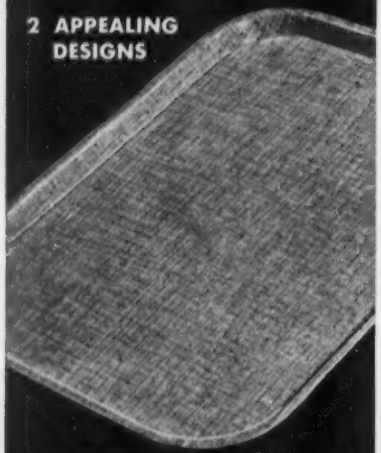

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What Is A Hospital For?

(Excerpts from a paper by Prof. J. M. Mackintosh, London School of Hygiene and Tropical Medicine, who is a member of the WHO Expert Advisory Panel on public health administration.)

The good hospital is *not* a structure bounded by four walls or even extended by pseudo-podial clinics. It is essentially a sphere of influence reaching far beyond its own curtilage to the homes of the families it serves. The hospital today should provide the best and most appropriate medical care for persons who are sick, whether (in acute, urgent, or difficult cases) in a hospital bed or a clinic, or a family dwelling. The hospital must go forth to meet and to destroy sickness. "I sent him into hospital" is an expression of failure not of triumph.

The good hospital constantly strengthens and supports its outposts—the general practitioner and other health services. The objective is to give such effective medical care in the early stages of sickness that the great misfortune of admission to hospital is avoided.

Let no one imagine that a hospital is a good thing in itself. So far as the patient and his family are concerned it is in the reserve line when the patrols and the supporting lines have been driven in. It is always late, always expensive; and its aims should be not expansion but extinction. Let me quote Dr. Hugh Paul (M.O.H., County Borough of Smethwick):

"Let us assume that a specialist officer of a regional board proposes a scheme for the treatment of his specialty, say neurosurgery. The first questions which will be asked by the board are: What is the extent of the demand for this service and what is the most economic way in which these demands can be met? This approach is wrong. The first question to be asked should be: In what way can these demands be met *without* the provision of hospital beds? How can the number of patients suffering from neuro-surgical conditions be reduced? In other words, the emphasis should be on the reduction of the demand rather than on the supply of beds to meet it. This approach makes the problem much more difficult. It is far easier, if much more expensive, to treat existing patients than to carry our investigations into the cause of the illnesses and the means at our disposal of preventing them."

It is the duty of the hospital, clearly, to cover all stages of illness up to final restoration, or as far as we can serve the patient by efficient treatment as opposed to custodial care. Treatment therefore begins at the moment of accident or illness and proceeds without interruption throughout the hospital phase and the convalescent phase, back to the home and the family physician. It is clear that the restorative process must be applied to the whole person who is sick and not just to that part of his mind or body that seems to present a symptom. As one eminent surgeon has said, "Anyone can cure a gastric ulcer but few can cure a patient with a gastric ulcer".

In the matter of prevention, the good hospital acts as an intelligence service, sending out when necessary danger warnings for the protection of the public. Its function is to watch the movement of sickness, to act early and with dispatch before great harm is done. One thinks at once of food poisoning, of an unusual number of cases of tetanus, or of something more sinister such as an outbreak of smallpox.

The appropriate field of study of a hospital is not sickness in the narrow sense but life in the broad sense. Sickness is an incident—grave, troublesome, or restful — in the life of a person; but to the hospital and its staff sickness is a challenge, a focus of inquiry from which prevention should radiate as well as the cure of the individual.

What is Research?

Research is a high-hat word that scares a lot of people. It needn't. It is rather simple. Essentially, it is nothing but a state of mind—a friendly, welcoming attitude toward change. Going out to look for change, instead of waiting for it to come. Research, for practical men, is an effort to do things better and not to be caught asleep at the switch. The research state of mind can apply to anything—personal affairs or any kind of business, big or little. It is the problem-solving mind as contrasted with the let-well-enough-alone mind. It is the composer mind, instead of the fiddler mind; it is the "tomorrow" mind, instead of the "yesterday" mind.—*C. F. Kettering*

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Bed Control Board

(Continued from page 70)

above procedure and governs himself accordingly. It is evident then that the more postponements of discharge dates have occurred, the more precise the discharge date may become.

The make-up of the control board is such that its arrangement depicts a display of bed locations arranged by class of service, namely private, semi-private (a) 2 beds; (b) 4 beds, and standard wards. In each of these classes of room service are listed the names of all medical departments. In this manner, the number of private, semi-private or standard wards assigned to each medical department becomes apparent.

The first fact that we learn from the doctor's application for admission is the medical service required by the patient; the second, is the class of service which the patient desires; the third, whether the patient's case is a routine one, urgent or emergency; fourth, the approximate length of time which the doctor estimates his patient's ultimate hospital residence to be. Fortified with such information, the control clerk is then in a position to go directly to the place at the control board where he is to find the desired class of service and the specialized medical attention requested by the patient.

Doctors, on the other hand, may call at the control room when they desire to ascertain for themselves the probable availability of beds for their patients.

As mentioned above, a coloured peg is inserted in the hole horizontally opposite the room and bed number representing the tentative date of discharge of a patient. A different coloured peg is used for each month. For instance, an orange peg may be used for the patient whose hospitalization interval is taking place during the month of September; the following month a yellow peg will be used to indicate the hospitalization interval, and still the following month, green pegs will be used for the same purpose. It becomes clear then, that as the plumb line progresses from day to day, the orange pegs of the month of September grow fewer and fewer in number, as the plumb line approaches to the end of the month and the yellow pegs typifying the month of October increase in number; and this feature repeats itself as the months roll by. However, if the discharge date of a patient has been postponed so many times that it reaches into the following month, the colour of the peg remains the same as that of the previous month among the differently coloured pegs of the present month, and so on.

Advance Reservation

In order to indicate "Advance Reservation" on a bed, prior to the discharge of a patient, a green U-shaped peg shall be inserted anywhere in the 31 holes available opposite the bed in question to indicate that this bed has been assigned. It is then imperative that if a resident patient is to be changed from a standard ward bed to a semi-private room or the other way around, or any other possible change between the standard wards or between semi-private and private rooms, the change cannot be effected until the control board operator has cleared the way.

In the case of a 24-hour bed assign-

(Concluded on page 92)

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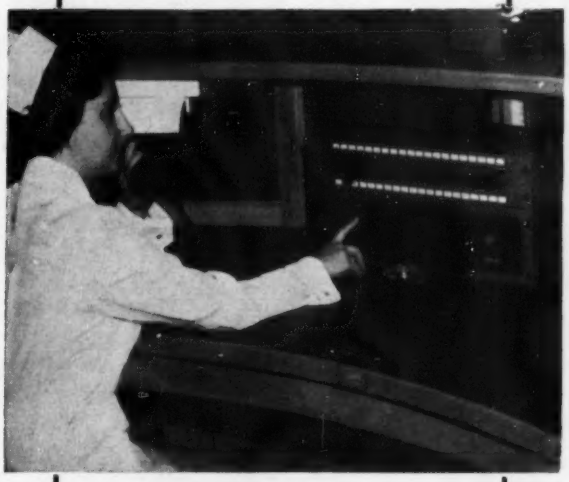

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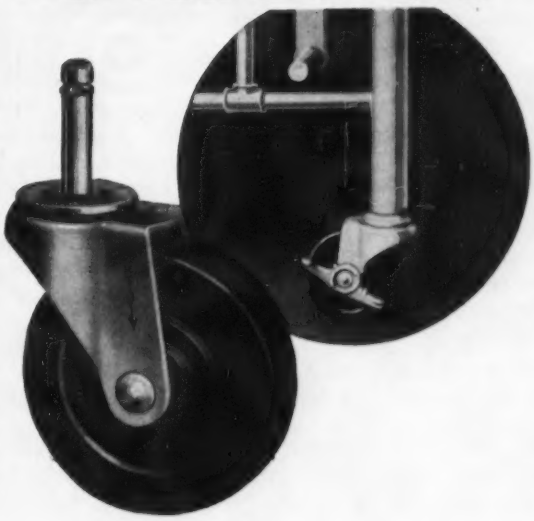

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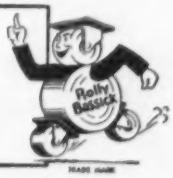

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Bed Control Board

(Concluded from page 90)

ment alert, a red U-shaped peg shall be used, in the same manner as described above, to indicate a similar status.

When a change has been cleared by the control operator, the supervisor of the floor in question forwards the service charge plate to the control room in order to enable the alteration of the room number. The control clerk will blank out and re-emboss the correct number of both the service charge plate and the corresponding 8-line master plate as well as the plate indentification labels and, at the same time, imprint by means of the hand-press the change of room and room rate, if any, on a form provided for that purpose and forward same to the accounting office, for correction of the Patients' Account Ledger Sheet.

It will be remembered that the patient's admission plate bears the date of the tentative discharge. If the patient should depart unexpectedly, the supervisor at the nurses' station informs the control room of this event. She learns of such a situation by comparing the current date with the date of discharge embossed at the bottom of the plate.

At the completion of the morning enquiries on all tentative discharge date pegs, 3 days away from the current day plumb lines, the control clerk notifies the accounting office of the verified discharges 3 days hence. This list assists the accounting office in preparing the accounts of patients and ensures that all charges have been entered on an account by the time the patient is ready to leave.

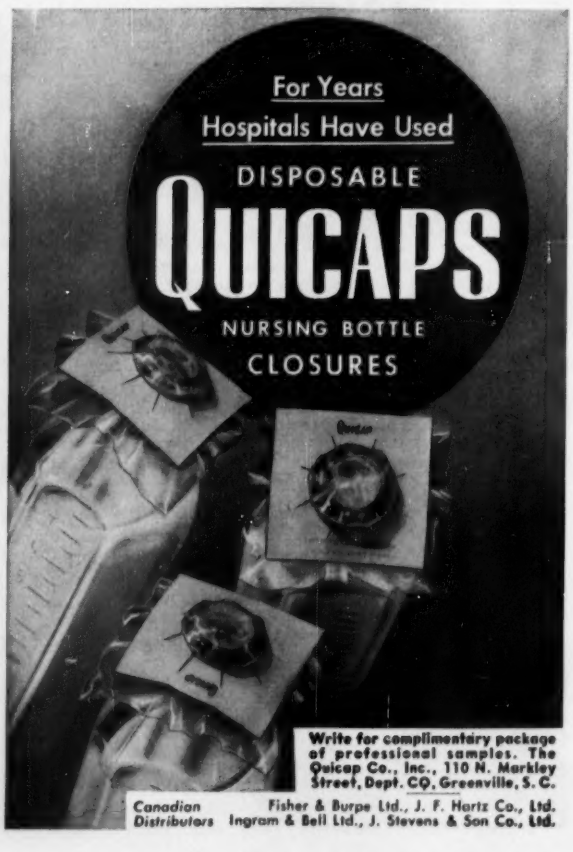
Night Admissions

A patient who does not come within the emergency class of cases shall not be admitted after six o'clock in the evening. Since the control board room closes at that time, and no direct bed assignment can then be made from that source, a list of rooms available in all classes of room services, as well as in all medical departments, shall be given to the emergency night admitting office. A special form shall be designed for the purpose. At the same time, the first hospital number assignable shall also be indicated. The following morning, the control clerk shall pick up the list from the superintendent's office and proceed to complete the admission plaques and paper routine of the emergency cases admitted.

Except in the case of hardship or for good and sufficient reasons, patients are not to be discharged on Sundays. The admission of patients on Sundays shall be on the same basis as night admissions, *i.e.*, routine patients shall not be admitted except during the first following week day, provided a bed is available or assigned.

B.C.H.I.S. pays $10,782 Account

The largest claim in the history of the British Columbia Hospital Insurance Service was approved for payment recently. The account totalled $10,782. It was paid on behalf of a patient who was in hospital and under almost continuous active, acute treatment from Dec., 1950 until June, 1953. Largest previous account was $7,000 for a hospital stay of about 18 months. On the average, 18,250 accounts are paid each month at a cost of about $1,986,000. This works out to an average of $109 an account.



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1. Rhoads, P. S., *GP* 5:67, February, 1952.

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Importance of Food in Preventive Medicine

The importance of nutrition in pellagra, diabetes, colitis, peptic ulcer, and anaemia is well known. Another area where food is of real importance is in the handling of the so-called febrile diseases. During fever there is an increased metabolism and, therefore, an increased requirement of certain nutrients. There is also an increased destruction of body tissues with the loss of nitrogen and often a disturbed water balance. Gastro-intestinal diseases offer perhaps the greatest difficulties to the nutritionist. Malfunction of the G.I. tract may entail certain putrefactive changes which produce toxic substances. Deficiency acids, it has recently been found, produce a rapid decrease in liver enzymes. The significance of these enzyme changes is not yet clear; but it is obvious that the metabolism of the liver is not normal and diseased conditions may result either suddenly or after long lapses of time.

The so-called reducing diets are another special concern of the nutritionist. If one wishes to reduce, the total fuel taken in must be below the total fuel required. This can be accomplished in many different ways but is easiest done by eating a large steak. The resulting high protein diet will not be harmful, provided all other nutritients, and especially vitamins and minerals, are supplied. Sound nutrition depends upon balance between all nutrients at a given time. This balance is best obtained through the consumption of common foods that are to our liking.—*American Journal of Public Health.*

Coming Conventions

Mar. 31-Apr. 2—Sectional Meeting of the American College of Surgeons, Montreal, P.Q.

May 31-June 2—Canadian Public Health Association Convention, Chateau Frontenac, Quebec City, P.Q.

June 7-11—Biennial Meeting of the Canadian Nurses' Association, Banff, Alta.

June 8-10—Canadian Dietetic Association Convention, Nova Scotian Hotel, Halifax, N.S.

June 14-18—Annual Convention of the Canadian Medical Association, Hotel Vancouver, Vancouver, B.C.

Aug. 14-21—Fifth International Congress on Mental Health, Toronto.

Sept. 7-12—International Conference of Catholic Nurses, Quebec City, P.Q.

Sept. 13-16—American Hospital Association Convention, Navy Pier, Chicago, Ill.

Oct. 12-15—Annual Convention of the British Columbia Hospitals' Association, Hotel Vancouver, Vancouver, B.C.

Oct. 25-27—Ontario Hospital Association Convention, Royal York Hotel, Toronto, Ont.

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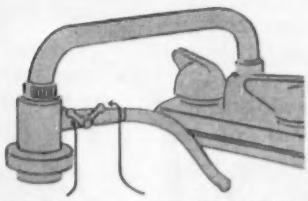

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A.H.A. Trustees Recommend Blue Cross for Military Dependents

The Board of Trustees of the American Hospital Association, meeting in Chicago, Ill., in December, recommended that hospital and medical care for military dependents be provided through Blue Cross and Blue Shield prepayment plans. The Board's position placed the Association in opposition to the proposal by a government commission that care for dependents be provided by the armed services in military hospitals wherever possible and in civilian hospitals only when military facilities are unavailable. The A.H.A. trustees felt that such a plan would encourage the building of a large military hospital system at great expense and prevent military dependents from having the privilege of free choice of hospital and physician.

Among other actions, the Board adopted a policy preventing the acceptance of advertisements in A.H.A. publications or exhibits at the A.H.A. convention from tobacco or liquor firms. No cigarette or liquor ads are now accepted but convention exhibits by tobacco firms have been accepted in the past.

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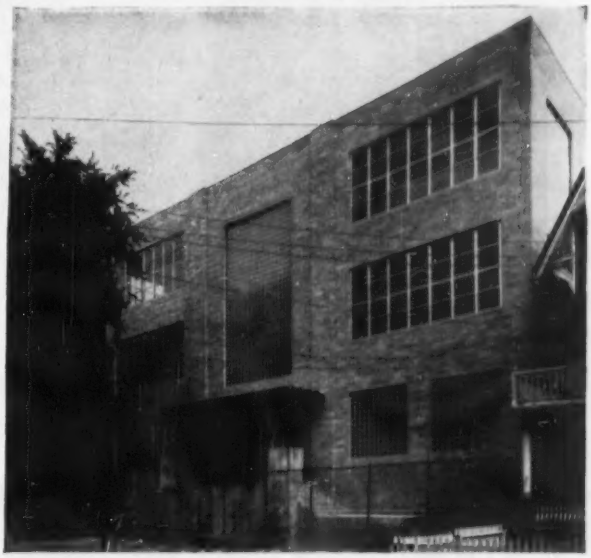

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Who Should Serve?

(Concluded from page 34)

sue in house planning. One has only to look at the lay-out of an old-fashioned house, with its overly-large kitchen often some distance from the dining room, its scattered work pattern for the housewife, and compare it with a modern scientifically designed kitchen, to see the analogy. Food brought through devious passages may arrive at the patient's bedside cold and tired looking. Disposal of garbage may be a time-consuming piece of drudgery, gathering and dispatching of soiled linen to the laundry may be a major traffic problem. There are scores of such situations that can be avoided by checking for such unnecessary mileage in and about the hospital before the cement is poured.

The choice of departmental heads should be left to the administrator and he must be careful to select those who have skill in the special field, have personality, character, and proved supervisory ability. This will make for a smooth running organization where the board works through the administrator and the administrator in turn works through the departmental heads in the properly constituted chain of command.

The purpose of this somewhat brief paper has been to set out in general terms some ideas regarding hospital management—from the standpoint of trustees and administrators. It is admitted that there are practical and tangible differences between the operation of a 50-bed hospital and one of 500 beds. However, the basic philosophy of such operation holds good for all hospitals.

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Staff Education

(Concluded from page 37)

meet changing conditions, face new demands and become familiar with new techniques . . . the reply, 'Our hospital can't afford it', is being 'penny wise and pound foolish'. In most cases they cannot afford not to do it."

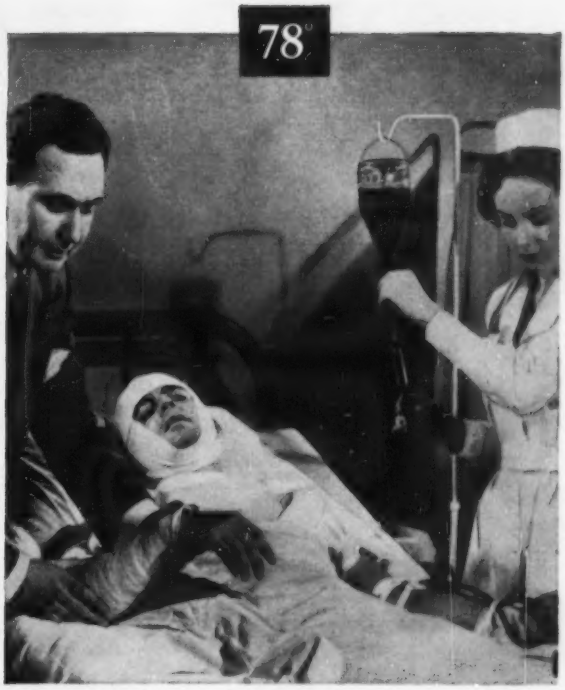
In assuming trusteeship, the trustee becomes responsible for the quality of hospital care. His main means of ensuring the best possible care are by engaging staff who are trained according to established standards and by encouraging continuing study and education. Because many forms of specialized training desirable for a hospital position are recent in origin, many executives lack special technical and scientific preparation. Such special education is of value to both employer and employee. Therefore, it should be a dual responsibility in order to gain a dual advantage.

Résumé

En devenant membre du bureau de direction, le directeur assume la responsabilité de la qualité des soins hospitaliers. Le meilleur moyen à sa disposition pour assurer les meilleurs soins possibles, est d'engager un personnel formé suivant des standards établis et d'en courager la poursuite de l'étude et de l'éducation.

Etant donné que bien des asnects de l'entraînement exécutif spécialisé, requis dans un hôpital sont d'origine récente, beaucoup de membres du personnel exécutif ne possèdent pas une formation technique et scientifique spéciale. Une éducation spéciale de ce genre est profitable à l'employeur comme à l'employé. Par conséquent, elle devrait constituer une double responsabilité visant à un double avantage.

IN ROOM 102, a patient waiting for diagnostic examination needs a 70° temperature. Since this hospital has Individual Room Temperature Control, it's simple to adjust the thermal environment in every room according to the patient's needs.



IN ROOM 103, next door, the Honeywell Hospital Thermostat is set at 78°, because this patient is recovering from surgery. The physician can make room temperature part of his prescription, if every room has its own thermostat.

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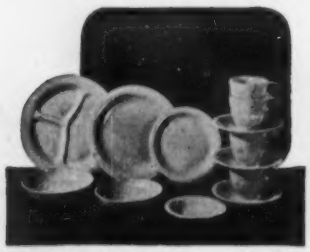

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Challenge and Opportunity

(Concluded from page 75)

there can be easy contact with consultants in all medical specialties. At the present time physical medicine departments tend to be assigned left-over space, such as top floors, former intern quarters, storerooms or basements. Incidentally, most new activities in hospitals were also started in cast-off facilities. It is still common to find radiology and pathology departments in basements or far corners, not to mention the makeshift quarters for metabolism tests and cardiography.

A new trend in medical practice offers great promise for the effective use of general hospitals. This is "home-care" for overflow-cases or people who require a minimum of professional supervision. Members of the hospital staff are assisted by visiting nurses and subordinate personnel or family members. Medical direction is provided without the expense of maintaining a bed in a general hospital. Consultants are called to the bedside or the patient may be transported to the hospital for special examination or treatment.

Home care is essentially a special form of hospital service. These hospital patients are merely located farther from the diagnostic centre of the institution than are other patients. In most instances, the professional personnel and equipment of the hospital would have been used only occasionally, even if these patients had been in the main building.

Home care exemplifies the fact that the essence of a hospital is the people who work for the institution. The patients remain under the same supervision but not necessarily under the same roof. A home care program carries to its logical conclusion the fact that the distinctive feature of a hospital is medical service, not custody.

Home care programs have not been developed widely by general hospitals. One explanation is the pre-occupation with acutely ill patients, particularly on the part of specialists who are unaccustomed to making house calls under any conditions. Another is the fact that ward-bed occupancy has been relatively low in many urban voluntary hospitals. Home care is not necessarily limited to charity cases. Up to the present time, many physicians and most hospital people have regarded home care service as a temporary expedient for handling overflow cases and not as a special form of hospital service.

Conclusion

Hospital trustees have a moral obligation to be intelligent in the use of personnel and facilities and to view their institutions in broad perspective. The history of the institution is written in its records of service and finance. The hospital's present role can be determined by facts concerning public attitudes, programs of other institutions, and data as to the unmet needs of the community. Knowledge of trends in professional practice underlies financial planning and support.

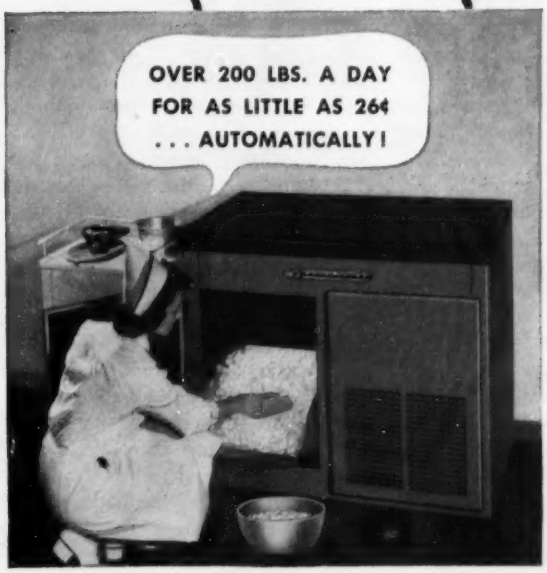
Hospital capital has always been provided by the general public without expectation of repayment or earnings on the investment. There is no reasonable prospect of change in this situation. Private donations are increasingly restricted to gifts by business corporations or foundations, which may be expected to regard hospitals as instruments of public service rather than memorials to worthy citizens.

Capital investment in hospitals, is withdrawn permanently from other forms of public service such as a school, a playground or a religious edifice. If money is unwisely invested in a hospital, it cannot be recalled to serve a more important function. It is too late to be prudent after the money has been spent.

A new or expanded hospital commits future generations to financing the care received at the institutions. But a hospital's service program and financial requirements are not predictable beyond the most general limits. An error in selection of personnel or supplies can be corrected by dismissal or a change to another vendor. But an unused building cannot be disposed of in so simple a manner. Before engaging in capital expansion programs, trustees should make every possible effort to assure themselves that an unmet need exists which would not otherwise be fulfilled. The responsibility for these important decisions is a challenge to which hospital trustees can devote their full measure of humanitarian impulse, civic pride, and capacity for leadership.

He who receives a good turn should never forget it. He who does one should never remember it. — *English Digest.*

Superior to crushed, chipped and flaked ice for every hospital need!



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No. 10

Meet the Men Who Serve You

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The genial Scotsman pictured above is "Bill" Cochrane of William Cochrane & Co., Vancouver, who represent G. A. Hardie & Co. Limited, in British Columbia and Alberta.

His many years' connection with the laundry, hospital, institution and hotel fields has caused his business to go ahead rapidly since its beginning a few years ago.

Bill is now thoroughly familiar with the wide variety of textiles included in the SUPER-WEAVE line. Many of these fabrics are of universal application, but wherever a special material is required special SUPER-WEAVE fabrics have been developed to fill the need.

The services of Hardie's manufacturing plant are also available to Bill's customers. He can supply made-up press covers, curtains for hospital cubicles, shade cloths for growers and any other special items made to the exact size required.

Here is what Bill has to say about Hardie's products: "SUPER-WEAVE is certainly becoming recognized as the mark of distinction in the textile field where we operate, and in places where it was unknown a year ago we find it is now the 'buy' word with many of our customers."

•

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A Graduate Reports

(Concluded from page 39)

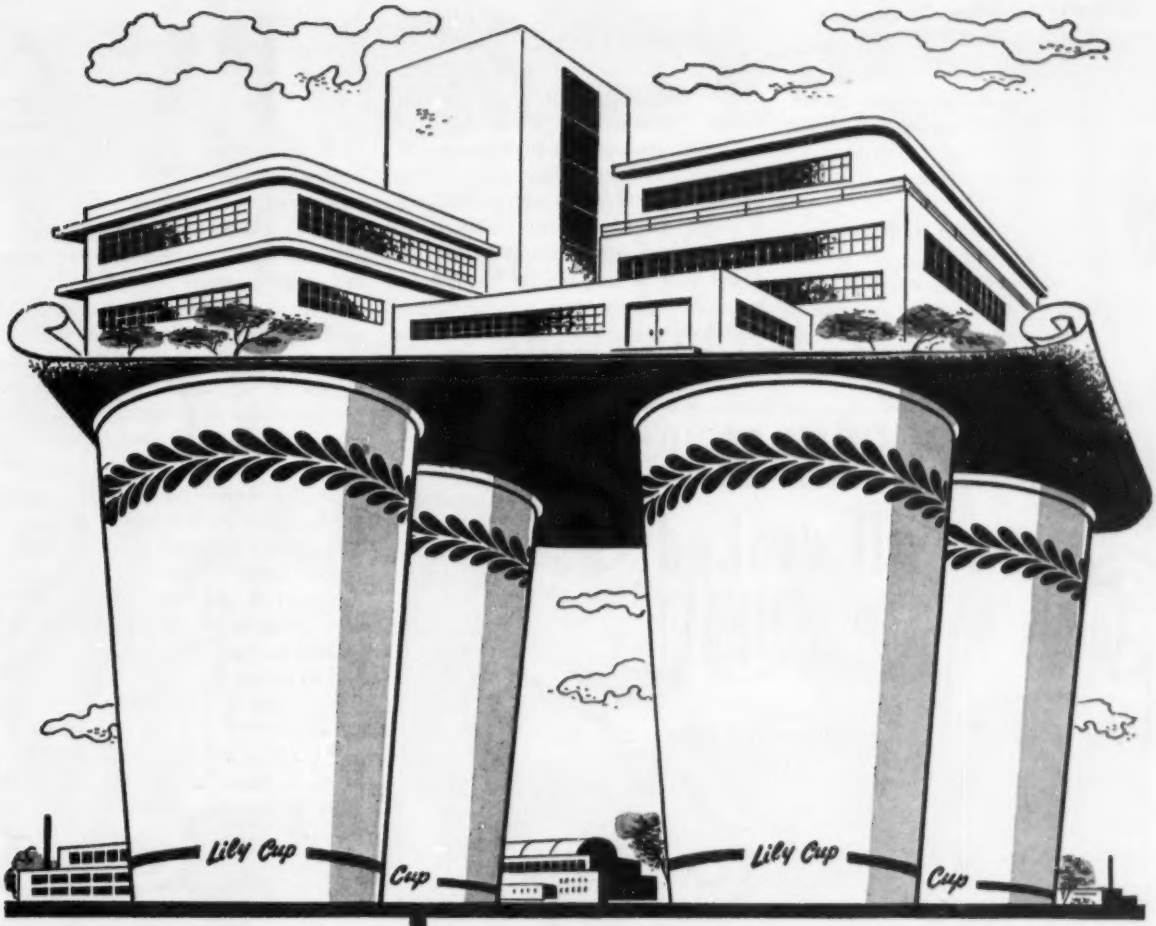
the student is working. However, there is some variation. A few lessons required solutions for problems that are frequently encountered in hospital organization. The length of time to be devoted to each assignment varies. Some are definitely more time consuming than others; but, as in everything else in life, one will get back just as much as is put into the course. Three hours daily is the time suggested by the Canadian Hospital Association. Many of the students were obliged to put in even more time than that in order to meet the deadline; others did not begin to use that number of hours. The availability of the required literature naturally influenced the length of time given to the readings; also, the number of years already spent as an executive in hospitals expedited the assignments for many students.

The summer courses were held in two sessions for the first year students —in June, 1952, there was a session in Kingston; in July-August, the western students met in Regina. Last year, the East and West were combined in one course at St. Anne de Bellevue, near Montreal. The Canadian Hospital Association provided an excellent faculty for all sessions. Men from various universities spent three to five days with us, both formally in the classroom and informally on the campus. In Regina and again this summer at St. Anne de Bellevue, Dr. Malcolm MacEachern dispensed his words of wisdom garnered from years of experience. The late Dr. Bachmeyer of the University of Chicago spent a week with the Kingston group. Numerous other well-qualified lecturers gave of their time and energy. Supervising and arranging the program throughout the year, encouraging and inspiring by his own personal enthusiasm, was Donald MacIntyre, whose untiring efforts have assured the success of this course. With him, Harold Dillon very ably arranged field trips to the various hospitals in the locality where specific departments were visited. Projects and seminars were allocated early in the session. Lectures were held daily, including Saturday. In the intervals between morning and afternoon sessions, there were movies on subjects such as fire protection, disaster planning, laundry management and business practice. There was always a project to prepare, meetings to attend, rehearsals for the presentation of one's project, or similar activities to occupy one's free time. In Regina, the class was divided into several sections, each one presenting a different subject, *e.g.*, a board meeting, a personnel interview, the presentation of the annual report, or a panel discussion. This summer the entire class worked on one joint project—a new 200-bed hospital to be constructed in an industrial city. The organization and planning for the hospital, the financing, construction, and staffing provided a subject for research. This gives you some idea of what we did with our leisure time.

What was Gained

One final question which has been asked is: "What have you derived from following the course?" My answer must necessarily differ from that of one who has spent a longer time in hospital work than I have. Everything was new to me; consequently I learned a great deal. This I have found of great practical assistance to me in my present position. Each day circumstances arise to which I can apply some of the many facts learned from the extension course. The principles laid down by the experienced lecturers, all equipped with a solid background of hospital work, give one a point of reference, in solving problems, which is extrinsic to the multitude of conflicting opinions and counsels offered one in a new administrative position. While such advice and assistance is invaluable, it is necessarily influenced by personal and department interests. Hence the chief executive who is responsible for the general welfare must have a definite criterion to guide her if she is to avoid being over-influenced by any special group. Years of experience with the groups involved should supply such a standard; but it is an advantage provided by the extension course that this criterion is available early in one's administrative career.

Others will doubtless find they have gained different benefits from the course. However, I believe that every one of us will agree that is has impressed on us the magnitude of hospital problems, while giving us confidence and a source of reference in dealing with them. It has stimulated us to continued study and research in order to improve existing methods and to provide similar opportunities for others.●



Build tomorrow's hospital on paper

Here are two facts of tremendous importance to architects, hospital superintendents and building committees:

1 — In one year, 500 hospitals changed to complete or partial paper meal service.

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Consider then the possibilities for economy when new hospitals are designed for paper service! There would be less space needed for kitchens, pantries; no need for elaborate dishwashing equipment, double sinks, soiled dish counters, endless supplies of soaps, powders, scourers. Far fewer employees would be needed.

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Catholic Nursing Conference

(Concluded from page 60)

and responsibility well established. In contacts with all personnel, there should be continual application of the psychological principles of human relations based on supernatural motivation.

6. Participants at the Institute recognized that the hospital which conducts a school of nursing assumes a dual responsibility: the care of the patient and education of students. Neither of these purposes may be subordinated to the other. To this effect, the director of the school, while working in the closest co-operation with the administrator of the hospital, should be given sufficient freedom to plan the teaching and clinical program according to the educational needs of the students. It should then be the responsibility of the hospital to meet the nursing service needs and to employ the number of graduate nurses and auxiliary help necessary to provide adequate care to the patients.

7. Because of the increasing financial implications for the hospital to maintain a school of nursing, a cost analysis should be done in every Catholic school of nursing and a budget established which would reflect the activities of the school. Every effort should be made by hospitals to continue operating schools of nursing and thus preserve the real, though sometimes intangible, advantages of such a pattern in nursing education.

8. Catholic schools of nursing should be interested in initiating experimentation in programs of nursing education. At the same time, they should safeguard sound educational principles based on Catholic philosophy, in any project undertaken.

9. Sisters engaged in nursing education have a duty to keep well informed on all current nursing education problems, to participate in the official nursing organization activities and to accept appointment on committees in which they can make a contribution.

10. Plans for the future should be made in terms of the entire scope of Catholic nursing education, with a view to preparing nursing personnel for Catholic hospitals and schools of nursing, assuring the perpetuation of the Christian concept of nursing and providing a Catholic education for Catholic students entering the nursing field. All within the Canadian Conference of Catholic Schools of Nursing should agree on basic policies and, as an organized group, unite efforts and co-operate wholeheartedly in order to serve the interests of nursing education in this country, as well as possible.

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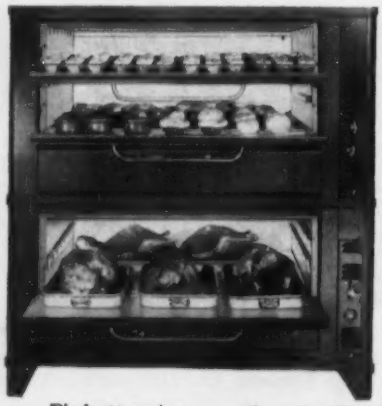

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Orange Juice for Grandparents

Everyone knows how vital orange juice is for babies. Now doctors point out that grandparents also benefit from goodly amounts of citrus juice.

In the February, 1953, issue of *Geriatrics*, Drs. E. T. Gale, and Malford W. Thewlin, writing on "Vitamin C and P in Cardiovascular and Cerebrovascular Disease", state: "An adequate vitamin C intake may prevent many illnesses in the aged. Incidence of disabilities from heart and cerebrovascular disease may be appreciably reduced. Research has shown that vitamin C plays a vital role in cellular metabolism and in maintaining the integrity of cells."

Scientific interest in the value of high quality meat products for very young infants has increased greatly in recent years.

Keeping pace with this trend Heinz has now added four Strained Meats to its already very complete range of Baby Foods. You can now prescribe 60 Heinz varieties that will meet every infant feeding requirement.

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Fund Accounting

(Concluded from page 48)

ulated and is, so to speak, "free". Furthermore, it is the policy of the hospital to transfer such "free" cash to the Plant Fund where it may be used to purchase replacements or pay off the indebtedness in that fund. The depreciation charged is assumed to be that in the following entries:

Revenue Fund Entries

Debit—Depreciation allowance — buildings and equipment $65,000
Credit—Due to Plant Fund —depreciation $65,000
To record depreciation allowance for period charged to operations and due to Plant Fund.

Debit—Due to Plant Fund —depreciation $65,000
Credit—Bank (Revenue Account) $65,000
To record transfer of cash being amount of the allowance for depreciation charged in the fiscal period.

Plant Fund Entries

Debit—Due from Revenue Fund $65,000
Credit—Accumulated Depreciation $65,000
To record fiscal period allowance for Depreciation provided in revenue fund expenditure.

Debit — Bank (Plant Fund) $65,000
Credit—Due from Revenue Fund $65,000
To record deposit of fiscal period depreciation allowance provided in Revenue Fund.

The carrying out of transactions, suggested in Supposition II above, for depreciation is generally referred to as "funding the depreciation allowance". This is considered to be a sound financial practice. Unfortunately, more often than not, because of operating deficits in the revenue fund and the need for further resources to support patients' accounts receivable, inventories, and the like, it is not possible for a transfer of cash to be made from the revenue fund to plant fund. In practice, the revenue fund will owe the plant fund for the depreciation allowance, less any disbursements out of the revenue fund made for the account of plant fund for the purchase of fixed assets and payments to creditors of plant fund both short and long term.

The entries, illustrated above, are all that are required to keep a balanced relationship between the various funds maintained in the hospital. The "due to" and "due from" accounts, like the equity account (fund capital account), should be susceptible of an analysis to reveal the details of the transactions carried through these accounts.

Advantages for the Hospital

While the hospital of a few years ago may not have needed appropriate accounting to tell its financial story, the hospital today cannot afford to ignore the potentialities of uniform accounting and this means fund accounting.

The hospital as a non-profit institution, with the motivating ideal of never refusing care even when the inability to pay is apparent, must tell its dollar story so the great bulk of the people using hospital services may be assured that the payments for care are equitable.

In this latter connection, third party paying agencies (the voluntary prepayment plans such as Blue Cross, charitable organizations and various governments) must know that patient billings are reasonable. The only way these agencies can properly and adequately appraise the economic situation is by interpreting and evaluating the finan-

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cial statements of the hospital.

Because hospital service is on a mixed basis of business and charity, there is great need for the type of financial information available in fund accounting. For instance, if all gifts received for charitable purposes by a hospital were in a separate fund; if there was one established rate for each type of service; and if all charity bills were paid out of the charity fund, then subsidization of charity service by private or x-ray patients would be eliminated. It is human nature to be charitable, yet there are those who suspect the hospital of using charitable gifts to subsidize patients who can afford and, in many cases, would willingly pay the full cost of their own care. The advantages of fund accounting in helping to carry out a sound policy toward charity, such as the care proposed here, are clear.

In addition, where the hospital seeks and receives restricted gifts and grants, there is the moral and legal duty to record and report as to their disposition. As pointed out, fund accounting is essential in looking after this type of obligation.

In administering the resources of the hospital and differentiating between the interests of the trustees and the administrator, fund accounting permits the paper segregation between fixed assets controlled by the former and the day-to-day operating resources which are the concern of the latter.

Fund accounting, if carried out completely in the hospital, points up sharply a current weakness in hospital financing, namely, the common failure to provide adequate resources in the revenue fund. It seems that it is much easier to solicit donations for the plant fund because the asset to be acquired can be identified. By developing and presenting financial statements in funded fashion, this unfavourable revenue fund situation can be clearly depicted for the comprehension of trustees, administrator, and all others interested in the finances of the hospital.

In all, fund accounting gives the hospital a means of presenting and interpreting the various phases of its business activities to interested outsiders. Finally, and by no means the least important, management is provided with an administrative tool, or means of control, which is much needed in an institution as complex as the modern hospital. ●

MORE THAN 100 CANADIAN HOSPITALS USE PIPELINES FOR MEDICAL GASES

FROM HALIFAX TO VICTORIA, B.C., most of the large hospitals and many of the smaller ones with 50 beds or more have installed pipelines for distribution of medical gases and for other purposes. A recent check shows that Canadian Liquid Air Company has been responsible for at least 75% of these hospital pipelines.

Why this trend to pipelines in hospitals? Experience has shown that not only do such lines provide maximum convenience — literally "gas on tap" — but their use effects very definite savings in money. Because the pipeline eliminates ordinary gas cylinders from wards and other locations in the hospital, cylinder handling costs are reduced accordingly — total handling can amount to at least 50c per cylinder.

IMPORTANT SAVINGS EFFECTED

The cost of gas also is cut because the central supply system, which is a feature of hospital pipelines, consists of large-capacity gas containers or bulk supply trailers — the hospital using trailers pays only for gas actually used.

Savings are continued all along the line with the hospital pipeline. Inexpensive flowmeters are used at the convenient wall outlets instead of expensive regulators which are necessary on individual cylinders. The cost of cylinder trucks is also eliminated in addition to a reduction in maintenance cost.

Then there is the saving of valuable space and, of course, the time of doctors and nurses concerned with the administering of gases. With the quick coupler provided at each pipeline outlet station in wards or rooms, a simple flowmeter for controlling and measuring the gas can be plugged in, in a matter of seconds, and the whole therapy treatment started within minutes. All the wasted time and inconvenience of bringing in cylinders of gas are eliminated.

BETTER EFFECT ON PATIENTS

Even the psychological effect on the patient is better. He now accepts oxygen therapy as standard treatment rather than a last resort.

Another convenience of the hospital pipeline is the installation of suction lines employing either the bottle trap system or direct sewer method. This has become commonplace in the larger hospitals.

Pipelines can be installed in new buildings and concealed from view, or placed directly on the walls of wards, etc., in older structures. The piping is of small diameter and, with the modern outlets, it is not unattractive.

For complete details about hospital pipeline systems, outlets and other equipment, consult any Liquid Air Branch office or write to Medical Gas Division, 1111 Beaver Hall Hill, Montreal, Que.

MEDICAL GAS DIVISION

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St. John's, Sydney, Halifax, Moncton, Quebec, Montreal, Toronto, Hamilton, Waterloo, London, Windsor, Sarnia, Port Arthur, Winnipeg, Regina, Saskatoon, Calgary, Edmonton, Vancouver, Victoria.

Provincial Notes

(Concluded from page 58)

in operation shortly. Built at an estimated cost of $25,000, the plant will replace four older boilers and furnaces. The new equipment will supply heat and hot water for the hospital and nurses' residence. When the old heating system and laundry room are removed from the basement, the space will be allotted to a new kitchen. Quarters occupied by the present kitchen will then be used for eight additional beds.

• • • •

PORT CREDIT. The proposed South Peel Hospital was given overwhelming approval by Toronto Township and Port Credit electors recently when they voted in favour of raising debentures totalling $350,000 for the hospital. Preliminary building plans for the first wing have been prepared and construction work will begin this summer. The first wing will contain 56 beds, 22 bassinets, operating room, delivery room, x-ray department, and other facilities, and will cost an estimated $750,000. The second wing will be added in the future and the over-all plan is designed so that accommodation can be increased to 200 or 250 beds.

• • • •

WINDSOR. It is expected that construction will begin this spring on the addition of a third floor to the Jeanne Mance nurses' residence at the Hotel Dieu Hospital. The $140,000 project will provide space for 36 additional beds. At present 115 nurses live in residence.

Quebec

COATICOOK. Work on the new Hôpital Ste. Catherine Labouré is nearing completion. The institution will have 89 active treatment beds, 18 bassinets, an out-patient department, and space will be provided to accommodate 11 nurses. The new hospital will serve an area which has a population of 12,000.

• • • •

HUNTINGDON. The official opening of the new Clouston Memorial Wing of the Huntingdon County Hospital took place in December. The hospital's total capacity is now 28 beds and nine bassinets.

Nova Scotia

NORTH SYDNEY. It is expected that the new 184-bed St. Elizabeth Hospital will be officially opened in May. The new building will replace the present Hamilton Memorial Hospital.

• • • •

YARMOUTH. An automatic sprinkler system has been installed throughout the Yarmouth General Hospital. A pump-house, required to house the pumps and water tanks, has been erected and the water tanks have a capacity of 6,000 gallons.

Youth is not a time of life—it is a state of mind. It is not a matter of ripe cheeks, red lips, and supple knees; it is a temper of the will, a quality of the imagination, a vigour of the emotions; it is a freshness of the deep spring of life. —*Samuel Ullman*

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Gluten-free Diet

(Concluded from page 56)

from, may be found in *Lancet* of November 8, 1952, page 905.

When a patient is placed on a diet employing these products improvement may occur in one to three weeks. The stools become less in volume and the patient's diarrhoea is relieved, as well as his distention and loss of appetite. He will then begin to gain weight and it is found that his fat excretion may return to normal. After a longer period the x-ray appearance returns to normal and glucose absorption improves. It must be emphasized that even the addition of one or two slices of toast to the patient's diet may throw off this recovery. It might be noted that toast is one of the foods which the patients miss most. There are a few patients who do not respond as well as most and these include many of the secondary types of steatorrhoea.

It is not known just what gluten does which is so bad for the patient and it seems certain that if work now in progress gives us this information we will have a much better understanding of the nature of the disease from which the patient is suffering. For example, it may be that the physical-chemical nature of gluten is such as to cause the disturbance attributable to the mucus and lead to a breakdown of the emulsification of the food. On the other hand, the disturbance may be metabolic and the patients who take gluten may actually excrete fat into the intestine and the change may be one in the interior of the body. Another possibility is that it is a bacteriological change which is produced when gluten is removed from the diet and a final suggestion has been that the patient is allergic to the protein and the reaction brought about in that manner. We will all wait with great interest the elucidation of these problems but, in the meantime, there is a great deal to be done to make these gluten-free products more palatable and more like ordinary wheat flour products. We must turn to the dietitians for help in this aspect of the condition.

The famous Great Windmill Street School of Anatomy, founded by William Hunter, was taken over by Sir Charles Bell in 1812 and became virtually a School of the Middlesex Hospital.—*H. C. Campbell.*

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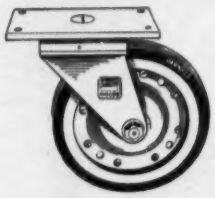

Hospital personnel and patients alike appreciate their "Efficient Quiet Operation", which is never found in the ordinary caster.

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They can be supplied with 8" or 10" Wheels.

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IN YOUR OPERATING ROOM?

We bring the following facts to your attention: When Green was first adopted for operating room gowns and sheets, there were no actual scientific facts available, except that green was known to be easy on the eyes. Consequently, all shades were used depending on the buyers' likes or dislikes. After consulting with leading eye doctors and research laboratories, we are pleased to offer our "FOCAL GREEN" based on the following facts:

1. *Its reflectance agrees sufficiently with that of the average between the skin and the incision or wound color, making less adjustment by the retina necessary when the eye moves from the linens to the operative area.*

2. *It avoids producing a red-sensitive eye. The retina can adjust to or from this color (and the wound colors) with less chromatic after-image. The ability to distinguish between the different shades of reds and pinks encountered during the more critical operations which involve vascular fields is increased by allowing the eye to return periodically to this color.*

3. *From an esthetic point of view, it has a better appearance than strong or harsh greens, and has a more pleasing, restful natural beauty than most colors. This color is "complementary" to the colors found in the vascular areas, and is conceded to "harmonize" with the other colors commonly found in operating rooms.*

Our S.G.12 O.R. Gown with stockinette cuff. Made in white or "FOCAL GREEN".

REMEMBER when the shade is DARK and REFLECTS no light, you might as well use black. You must have a shade which reflects approximately as much light as the object which you are working on and is complementary to these shades. Our "FOCAL GREEN" is this shade, founded on scientific fact, and is being featured in our new catalogue. Why not write for this catalogue which features all the best in Textiles and Garments for Hospital use and rest assured that this "Focal Green" is right for use in your operating room. Samples of the shade are available on request.

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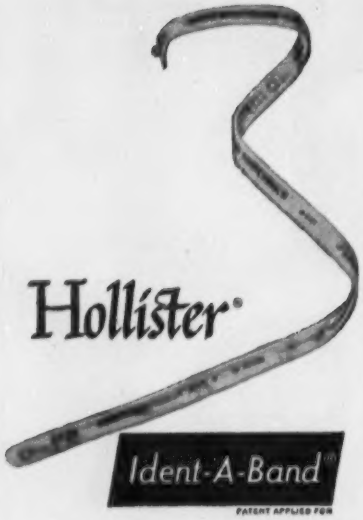

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ADDRESS .....

Belleville General Holds Blood Donor Clinics at Night

The problem of arranging appointments for blood donors to the mutual satisfaction of both donors and hospital has been dealt with satisfactorily at the Belleville General Hospital, Belleville, Ont. In the past, persons replacing blood given to a patient could come to the hospital at any time of the day or night. However, they came during busy periods and had to wait for some length of time or in the evening when the laboratory was closed and when it was more difficult to carry out the procedure. Therefore, it was decided to hold a weekly Blood Donor Clinic.

When a patient receives a blood transfusion, a notice is sent to the nearest relative with a request for names of prospective blood donors. Along with the notice, goes a copy of a pamphlet, *Blood Donor Service—How it operates,* which explains why it is necessary to replace the blood. When the names of donors are received, a notice is sent to them to attend the next Blood Donor Clinic, if it is convenient, or one on a subsequent night. The clinic is open every Tuesday evening from 6:00 to 8:30 and, during this time, one laboratory technician, a graduate nurse, and a doctor are in attendance.

The system has proved to be very satisfactory. Donors are more satisfied since waiting time has been reduced and they are given the necessary care and attention. There is quite a saving in employee time as well and less confusion. In addition, it has been found that the blood bank is better stocked than in the past.—*From "Hospital Highlights", Nov.-Dec.,* 1953.

Conference on Care of Long-term Patient

A national conference on the care of the long-term patient will be held in Chicago, Ill., from March 18th to 20th. It will be under the auspices of the Commission on Chronic Illness and co-sponsored by its supporting groups and the U.S. Public Health Service. The Commission was founded and is supported by the American Hospital Association, the American Medical Association, the American Public Health Association, and the American Public Welfare Association.

A contented mind is the greatest blessing a man can enjoy in this world.—*Joseph Addison*

Director of Dietary Services

Applications are invited for the position of Director of Dietary Service—for a 500-bed Medical Teaching Hospital. High administrative qualifications and broad knowledge required to the end that the most suitable system of food distribution can be incorporated in present major building programme. Salary open.

Address applications to the Superintendent's Office, Kingston General Hospital, Kingston, Ontario, Canada.

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(Qualified)

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Apply Mr. J. McIntyre, Administrator, Winnipeg Municipal Hospitals, Winnipeg, Manitoba.

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Fully qualified Physiotherapist required immediately for modern new 225 bed hospital at Moncton, New Brunswick. Salary open. Write Executive Director, Moncton Hospital, Moncton, N.B.

Qualified Dietitian Wanted

Saint John Tuberculosis Hospital, East Saint John, N.B. requires qualified dietitian. Straight time. Apply Dietitian.

Positions Wanted For Nurses

Let us help you with your MEDICAL PERSONNEL problems!

International Employment Agency,
29 Park, W., Room 209, Windsor, Ont.

Superintendent Wanted

For 100-bed hospital. Applicant must be a Graduate Nurse with administrative experience. Apply, stating salary, to Box 264P, The Canadian Hospital, 57 Bloor Street West, Toronto.

Laboratory Technician Wanted

Qualified Technician, preferably with special training for 100-bed hospital. Apply, stating salary expected and earliest date available to Superintendent, Soldiers' Memorial Hospital, Campbellton, N.B.

Physiotherapist Wanted

Physiotherapist wanted for the two hospitals in Prince Albert, Sask. Salary open. Apply stating qualifications and experience to either the Victoria or Holy Family Hospital, Prince Albert, Sask.

CUTTER DEXTRAN

a low cost plasma volume extender

CUTTER DEXTRAN is a 6% W/V solution of the partially hydrolyzed macromolecular polysaccharide dextran in isotonic sodium chloride. It is indicated for the correction of hypotension due to hemorrhage, burns, trauma and surgical shock. When blood volume deficit does not exceed one third, it may serve alone as a replacement fluid, otherwise whole blood will be needed later to overcome the anemia.

Quick Increase of Plasma Volume

Dextran infusion increases effective circulatory blood volume and supports colloid osmotic pressure of the blood during the shock state.

It was found that following the administration of 500 cc. of Dextran to 6 non-shock patients, blood volume increase amounted to an approximate average of 1,000 cc. in 15 minutes and 1,100 cc. in 45 minutes. At 1 hour 15 minutes, the blood volume increment dropped to 900 cc. and increased to 1,350 cc. at 5 hours. A slight decrease was noted between 5 and 8 hours, the increase being 1,100 cc. at 8 hours. A gradual reduction followed until 20 hours, there being a net increase of 275 cc. at this time.

1,000 cc. and larger amounts of Dextran may be given when necessary without deleterious effect. Should the shock patient fail to respond satisfactorily, however, a whole blood transfusion should be given as soon as possible.

From 25% to 40% of administered Dextran is recoverable in the urine in twenty-four hours. The remaining fraction has shown no harmful effects on the tissues; indications are that most if not all of this is metabolized by the body.

Because of Dextran's molecular size, it does not readily pass through blood vessel walls and thus, pulls edema fluid back to the blood stream by osmotic forces. Resultant hemodilution and increased plasma volume is of sufficient duration to enable the circulatory system to overcome its shock-altered dynamic state.

Advantages

The relatively low cost and easy availability of Dextran are of extreme importance, particularly in the light of the crucial need for whole blood. As a therapeutic agent, Dextran is non-toxic and non-pyrogenic and, unlike plasma, will not transmit the virus of hepatitis. It is stable and liquid under normal clinical conditions, appearing to stay in solution indefinitely.

In storage it requires no refrigeration. Dextran is ready for *immediate* administration since typing, grouping and crossmatching of blood are precluded. To facilitate administration, Cutter Dextran is supplied in 500 cc. Saftiflasks with the exclusive Saftitab Stopper and may be given quickly and easily with any standard administration set.

Disadvantages and Precautions

The two major disadvantages of Dextran are (1) it provides no protein nutrient and (2) it is a plasma extender *only*. In cases of severe hemorrhage, maximum increases in circulating blood volume and restoration of the *oxygen carrying capacity* of the blood can only be provided by the administration of Whole Blood.

Where the hazard of congestive heart failure and pulmonary edema may be present (e. g. those patients with heart disease and renal shutdown), special care should be taken in the administration of Dextran.

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*T. M.

Electron Linear Accelerator

A powerful new tool of nuclear research—Stanford University's billion-volt, super-high-frequency, 200-foot-long electron linear accelerator—is going to be made in junior sizes for cancer therapy and inspection of industrial products.

The "toned down" accelerators will be manufactured and sold by the x-ray department of the General Electric Company under a 10-year agreement with the University, according to a joint announcement released recently. They should be on the market within the next few years.

Six-million-volt electron "bullets" will be fired at cancer from this glass-enclosed "gun" being tested by Donald H. Janney, Stanford University graduate student.

G. E. engineers will spend a year at Stanford studying the design and construction of linear accelerators, including a pilot medical accelerator now being built. This six-million-volt, six-foot machine will be installed at Stanford School of Medicine in San Francisco, where radiologists plan to use it against deep-seated cancer by the end of 1954.

Standford - designed accelerators "shoot" electrons in a straight line through a copper tube at almost the speed of light—approximately 186,000 miles per second.

The electrons ride surfboard-style on microwaves produced by klystrons, the most powerful vacuum tubes made. High-voltage x-radiation can be produced when a metal target is placed in the beam's path.

This radiation has advantages over lower-voltage x-rays in treating deep-seated cancer, according to various medical reports. More of the high-energy radiation reaches the depths of the body, less of it affects the skin.

There is also more uniform absorption of the x-rays by bone, fat, and muscle, instead of greater absorption by bone. This reduces the tendency of bone to be damaged while other areas are being treated, and prevents "blind" or untreated areas behind bones.

The electron beam may also be used in cancer treatment without converting it to x-rays, according to Professors Edward L. Ginzton and Henry S. Kaplan, joint directors of the pilot medical accelerator project.

The following three national organizations supplied funds which are aiding in the development of the linear accelerator: The Office of Naval Research, the American Cancer Society, and the National Cancer Institute of the National Institutes of Health.

Free Offer of Alconox

Alconox, Inc., Jersey City, N.J., manufacturers of the internationally known hospital, laboratory and industrial detergent, Alconox, has commenced a greatly increased sales promotion campaign for 1954.

In order to further the ever increasing sales of their product, the company is offering in advertisements and literature between 35 to 50,000 free 3-lb. sample containers of Alconox to hospitals, laboratories and other pertinent industries where clean, film-free, equipment of glass, metal, plastic, porcelain, etc. is of paramount importance.

For further information write the Canadian distributors, Canadian Laboratory Supplies Limited, Jane and Dundas Streets, Toronto.

New Appointments at Abbott Laboratories Ltd.

At a recent sales convention, H. S. Wilkinson, vice-president and director of sales of Abbott Laboratories, North Chicago, Ill., announced the appointment of Adrien Hebert, formerly district sales manager of Quebec and the Maritime Provinces, as Canadian

Adrien Hebert

divisional sales manager. Mr. Wilkinson also announced the appointment of G. R. Tremblay as district sales manager of Quebec and the Maritime Provinces.

Wheel Stretcher, Plus Wheel Chair

The new "Hausted Conver-Table", model 500, is said to be the most versatile piece of equipment ever offered to the medical profession. In five seconds, this new "Conver-Table"

(Concluded on page 116)

When planning a laboratory....

USE A *Canadian* CATALOGUE

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The complicated arrangements of pipes and fittings for electric conduit, water, gas, air, vacuum and steam lines, traps and drain lines, within the extremely limited space behind a wall table or between the cabinets of a centre table, present a very real problem if the usefulness of the table itself, or valuable floor-space is not to be sacrificed.

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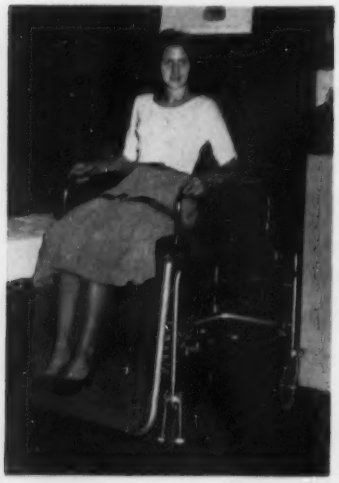
Across the Desk

(Concluded from page 114)

can be quickly and easily converted from a wheel stretcher into a most comfortable wheel chair. For the first time, the arthritic, polio, paralytic and invalid patient can be given relief from the bed position. The patient can be transfered from the bed onto the flat horizontal stretcher top.



By releasing the top, it will roll forward and break, thus lowering the legs and then the Fowler attachment, or back rest can be raised to any desired position. The small side rails can be placed in position providing an arm rest. The restraining straps attached to the lower frame can be placed over the lap, holding the patient in a secure position. A foot board is available for patient comfort.

This multi-purpose unit can be used as an emergency O.B. table, examining table, wheel stretcher, post-operative stretcher and wheel chair.

Changes in Pyrene Company

Harold B. Weed, president of Pyrene Manufacturing Company of Canada Limited, has announced that The Pyrene Company Limited, of London, England, entered into a contract covering the purchase of the entire share capital of the Canadian Company from the Pyrene Manufacturing Company of Newark, New Jersey. The Pyrene Manufacturing Company of Canada Limited now becomes a wholly-owned subsidiary of The Pyrene Company Limited of London.

Mr. Weed, who will continue as president and managing director of the Canadian company, advises that this change will considerably increase the activities and operations of the company since The Pyrene Company Limited of London ,England, has for many years, in addition to the well-known Pyrene Fire Extinguisher line, produced and manufactured a number of other products, the majority of which will now be distributed by the Canadian subsidiary. It is anticipated that the broadening of the scope of the Canadian company's activities will lead to further growth and expansion.

President of Bauer & Black

The election of D. F. Kent as president of Bauer & Black, surgical dressings' division of The Kendall Company (Canada) Limited, has been announced by the directors of the company. Formerly vice-president and general manager, Mr. Kent will also continue in the latter capacity.

Announced at the same time is the appointment by Mr. Kent of J. D. W. Gwynne, sales manager, to the position of general sales manager.

Mr. Kent, a native of Meaford, Ontario, was educated at the University of Toronto Schools and was in the Commerce and Finance Course at the University of Toronto.

He joined the Bauer & Black Division of The Kendall Company in Chicago after a year with the A. B. Dick Company in that city where he organized the training and selection department. He returned to Canada as general manager of Bauer & Black Division of The Kendall Company (Canada) Limited.

Mr. Gwynne, a native of Hawkesbury, Ontario, has been associated with Bauer & Black for seventeen years. He joined the production department of the company in 1936 and in 1938 was transferred to the sales department. Two years later he moved to the Chicago office of the organization. In 1946, after his discharge from the Army, Mr. Gwynne became field sales manager and was appointed sales manager in 1950.

Tests Proves Ink Marking Outlasts Cloth

The photograph below shows the result of "washing to death" a heavy cotton hand towel. The centre area was marked with Applegate Silver Base Indelible Ink. Ordinary markings were used on the edges of the towel. The towel was then washed until the material wore out. Ordinary markings almost faded out, but even the bleaches did not affect this special hospital marking ink.

Use of an absolutely indelible ink saves time re-marking, speeds sorting of linen, and by marking the date put in use the housekeeper knows exactly how long linens are lasting. For complete information on marking linens for hospital use, write for "The Applegate System", Attention: Mr. C. I. Fritz, Applegate Chemical Co., 5632 South Harper Avenue, Chicago 37, Illinois.

Nife and Britannia Batteries Now Marketed in Canada

Two of Britain's largest manufacturers of alkaline storage batteries have announced the appointment of The British General Electric Co. (Canadian) Ltd., as sales agent for their products in all provinces except British Columbia and Alberta. Although Nife and Britannia Batteries have enjoyed large scale production for many years and have a world-wide reputation for long life and reliability, this is the first time that a British-made alkaline battery has been available, with distribution and service facilities, to the Canadian market. There is a rapidly growing interest in alkaline batteries, both for many special defence problems and for a wide range of industrial and institutional uses. These new agency arrangements should be another step towards increased trade between the U.K. and Canada.

Retired Workers Become Craftsmen

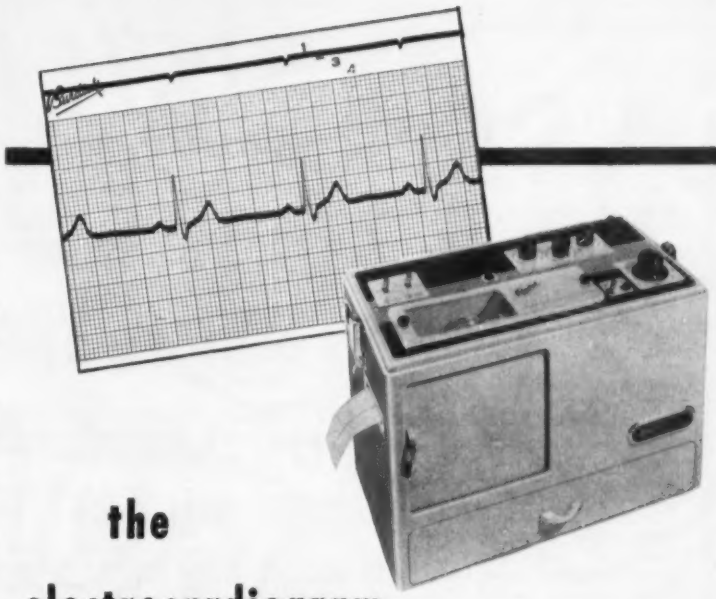
A favourite topic of discussion at conferences and seminars on the problem of the aged is the idea of creating part-time occupations for the retired worker. At Holly Hill, Florida, this idea has been put into practice, appropriately enough, by a retired businesman, Paul M. Bryant. Recently, he became interested in early American furniture and decided to set up a small factory where such furniture could be made. He engaged a working force composed entirely of retired or disabled workers. They discarded the production line techniques and are using, for the most part, the hand craftsmanship methods which were in vogue a century or more ago. The emphasis is on skill rather than production schedules. Each man works on the things he likes best to do, in his own way and at his own pace. The only requirement is that each piece conform to one of the 20 standard patterns established to ensure a certain uniformity to the shop's output.

The plant has a showroom where the furniture is displayed for sale and the guest register shows buyers from most of the 48 states. The heaviest demand, however, is local, since the buyers like to see their furniture in the making.

Mr. Bryant selected early American furniture as the basis for his project because of the simplicity of its construction, which could be easily mastered by older men whom, he believes, are natural craftsmen. Previous experience in woodworking is not necessary to obtain employment. One of the employees was formerly a women's garment maker in New York, another spent years as a concrete construction contractor, and another was disabled because of loss of sight in one eye. Others, however, are retired cabinet makers who are thus making use of previous skills. If success continues, Mr. Bryant looks forward to making the business a co-operative enterprise with the workers sharing in the profits. — *From "Aging", Nov., 1953, published by the U.S. Department of Health, Education, and Welfare.*

Oldest Hospital in Britain

St. Bartholmews Hospital in London was founded by Rahere in 1123. It is the oldest hospital in Britain and has had Royal Patronage since its early history. — *"Alberta Medical Bulletin."*



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*The Med. Clin. of North American (Jan.) 1952, p. 93.

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PIERRE MERCIER & CIE., LTEE., MONTREAL

Index of Advertisers

FEBRUARY, 1954

A

American Cystoscope Makers Inc. 57
American Sterilizer Company 22
Applegate Chemical Company 106
Armstrong, S. A. Limited 95
Art Woodwork Limited 115
Astra Pharmaceutical Products Inc. 24
Ayers Limited 96

B

Banfield, Arnold & Company Limited 100
Bard, C. R. Inc. 9
Bassick Division, Stewart-Warner Corp. of Canada Ltd. 91
Bauer & Black, Division of Kendall Co. of Canada Ltd. 8, 49
Baxter Laboratories of Canada, Ltd. 5
Blakeslee, G. S. & Co. Limited 7
Blodgett, G. S. Company Inc. 104
Bode, Walter & Co. Limited 86
Booth, W. E. Co. Limited 80
British Oxygen Canada Limited 79
Brock, Stanley Limited 82
Brunner Mond Canada Limited 29
Burdick Corporation 117
Burke Electric & X-Ray Co. Limited 117

C

Campbell, Cooper Company 72
Canadian Hoffman Machinery Co. Limited 90
Canadian Johns-Manville Co. Limited 71
Canadian Laboratory Supplies Limited 27
Canadian Laundry Machinery Co. Limited ..... Ii Cover
Canadian Liquid Air Co. Limited 107
Cash, J. & J. Inc. 108
Cassidy's Limited 65
Castle, Wilmot Company 81
Casgrain & Charbonneau Limited 81, 117
Chaput, Paul Limited 91
Colgate-Palmolive-Peet Co. Limited 69
Connor, J. H. & Sons, Ltd. 78
Continental Surgical Supply Co. Limited 68
Corbett-Cowley Limited ..... III Cover
CorDest Garments Limited 108
Crane Limited 30
Cutter Laboratories 113

D

Dalex Company Limited 110
Darnell Corporation of Canada Limited 110
Davis & Geck Inc. ..... 14 - 15
Dixie Cup Company (Canada) Limited 83
Dominion Glass Co. Limited 67
Dustbane Products Limited ..... 10 - 11

E

Eaton, T. Co. Limited 106
Electro-Vox Inc. 91

F

Fisher Bearings (Canada) Limited 96
Fisher & Burpe Limited 73, 117
Frigidaire Products of Canada Limited 101
Foodcraft Laboratories Limited 16

G

Garland-Blodgett Limited 104
General Electric X-Ray Corporation Limited 53
Gestetner (Canada) Limited 76
Gevaert (Canada) Limited 98

H

Hardie, G. A. & Co. Limited 102
Hartz, J. F. Co. Limited 26
Heinz, H. J. Co. of Canada Limited 105
Hotel & Hospital Supply Company 23
Hollister, Franklin C. Company 112
Horlick's Limited 20

I

Ilford Limited 80
Imperial Surgical Company 63
Industrial Textiles Limited 111
Ingram & Bell Limited 5, 22, 57, 109

J

Johnson & Johnson Limited 18, 55
Johnson, S. C. & Son Limited 13

K

Kraft Foods Limited 74

L

Lac-Mac Limited 4
Lederle Laboratories 59
Lily Cups Limited 103

M

Macalaster-Bicknell Parenteral Corp. 87
McKague Chemical Co. Limited 95, 97
Merck & Company Limited 51, 93
Metal Craft Co. Limited 75
Minneapolis-Honeywell Reg. Co. Limited 99

N

National Cash Register Co. Limited 85

O

Oakite Products of Canada Limited 90
Office Specialty Manufacturing Co. Limited 94
Ohio Chemical Canada Limited 25

P

Picker X-Ray of Canada Limited 3

Q

Quicap Company Inc. 92

R

Rainbow Plastic Limited 88
Russell, F. C. Co. Limited 97

S

Seamless Rubber Company 17
Skinner, Ella Uniforms 92
Sterling Rubber Co. Limited 89
Stevens Companies, The 24 28, 81, 84, 87
Stewart, Colin Limited 77

T

Taylor, Edward Limited 84
Texpack Limited 21

U

United-Carr Fastener Co. of Canada Limited 23

V

Vollrath Company, The 109

W

West Disinfecting Co. Limited 64
Wilmot Castle Company 81
Wood, G. H. & Co. Limited ..... IV Cover
Wyeth, John & Brother (Canada) Limited 61

X

X-Ray & Radium Industries Limited 19

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